

Facility Name & ID Number Rosewood Care Ctr Northbrook

0042341 Report Period Beginning: 7/1/07 Ending: 6/30/08

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	147	Skilled (SNF)	147	53,802	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	147	TOTALS	147	53,802	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				
		2 Medicaid Recipient	3 Private Pay	4 Other		5 Total
8	SNF			4,816	4,816	8
9	SNF/PED					9
10	ICF	28,415	8,271		36,686	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,415	8,271	4,816	41,502	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.14%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 6/22/1998

J. Was the facility purchased or leased after January 1, 1978?
YES Date 6/22/1998 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 30 and days of care provided 4,816

Medicare Intermediary TriSpan Health Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30 Fiscal Year: 06/30

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

Facility Name & ID Number Rosewood Care Ctr Northbrook # 0042341 Report Period Beginning: 7/1/07 Ending: 6/30/08

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

	Operating Expenses	Costs 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
	A. General Services										
1	Dietary	280,486	33,335	7,773	321,594		321,594	3,629	325,223		1
2	Food Purchase		212,651		212,651		212,651	(435)	212,216		2
3	Housekeeping	173,649	44,381		218,030		218,030		218,030		3
4	Laundry	58,896	15,855		74,751		74,751		74,751		4
5	Heat and Other Utilities			219,819	219,819		219,819	283	220,102		5
6	Maintenance	38,753	13,300	157,888	209,941		209,941	17,693	227,634		6
7	Other (specify):* Waste Collection			12,135	12,135		12,135		12,135		7
8	TOTAL General Services	551,784	319,522	397,615	1,268,921		1,268,921	21,170	1,290,091		8
	B. Health Care and Programs										
9	Medical Director			9,140	9,140		9,140		9,140		9
10	Nursing and Medical Records	2,578,442	177,287	88,828	2,844,557		2,844,557		2,844,557		10
10a	Therapy	106,501	1,218	488,215	595,934		595,934	61,282	657,216		10a
11	Activities	63,453	3,239	2,156	68,848		68,848		68,848		11
12	Social Services	42,891		1,026	43,917		43,917		43,917		12
13	CNA Training										13
14	Program Transportation			72	72		72		72		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,791,287	181,744	589,437	3,562,468		3,562,468	61,282	3,623,750		16
	C. General Administration										
17	Administrative	108,122		170,831	278,953		278,953	(160,773)	118,180		17
18	Directors Fees										18
19	Professional Services			33,078	33,078		33,078	18,581	51,659		19
20	Dues, Fees, Subscriptions & Promotions			69,759	69,759		69,759	(47,615)	22,144		20
21	Clerical & General Office Expenses	200,536	22,884	20,447	243,867		243,867	132,822	376,689		21
22	Employee Benefits & Payroll Taxes			408,035	408,035		408,035	22,805	430,840		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,647	6,647		6,647	4,251	10,898		24
25	Other Admin. Staff Transportation			4,600	4,600		4,600	4,467	9,067		25
26	Insurance-Prop.Liab.Malpractice			55,010	55,010		55,010	6,147	61,157		26
27	Other (specify):*										27
28	TOTAL General Administration	308,658	22,884	768,407	1,099,949		1,099,949	(19,315)	1,080,634		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,651,729	524,150	1,755,459	5,931,338		5,931,338	63,137	5,994,475		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 Ctr Northbrook

#0042341

Report Period Beginning:

7/1/07

Ending:

6/30/08

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	
	D. Ownership											
30	Depreciation			4,809	4,809		4,809	266,483	271,292			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,136,458	1,136,458		1,136,458	(375,215)	761,243			32
33	Real Estate Taxes			110,941	110,941		110,941		110,941			33
34	Rent-Facility & Grounds			764,566	764,566		764,566	(744,438)	20,128			34
35	Rent-Equipment & Vehicles			17,759	17,759		17,759		17,759			35
36	Other (specify):*											36
37	TOTAL Ownership			2,034,533	2,034,533		2,034,533	(853,170)	1,181,363			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		159,787	18,291	178,078		178,078		178,078			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			77,553	77,553		77,553		77,553			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		159,787	95,844	255,631		255,631		255,631			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,651,729	683,937	3,885,836	8,221,502		8,221,502	(790,033)	7,431,469			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 Ctr Northbrook

0042341

Report Period Beginning: 7/1/07

Ending: 6/30/08

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	(225)	2		4
5	Telephone, TV & Radio in Resident Rooms	(70)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(17,627)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(210)	2		13
14	Non-Care Related Interest	(1,136,458)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(3,000)	20		17
18	Fines and Penalties				18
19	Entertainment	(125)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(762)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(37,451)	20		25
26	Income Taxes and Illinois Personal				26
27	Property Replacement Tax				27
28	CNA Training for Non-Employees				28
29	Yellow Page Advertising	(7,164)	20		29
30	Other-Attach Schedule	(82,214)	21		30
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,285,306)		\$	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)	495,273	VAR	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 495,273		36
(sum of SUBTOTALS)				
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (790,033)		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	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Care Ctr Northbrook

ID# 0042341

Report Period Beginning: 7/1/07

Ending: 6/30/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Marketing Salary	\$ (82,214)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48	Total	(82,214)		48
49				49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Ctr Northbrook# 0042341 Report Period Beginning:7/1/07Ending: 6/30/08**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)	
	A. General Services													
1	Dietary	0	0	3,629	0	0	0	0	0	0	0	0	3,629	1
2	Food Purchase	(435)	0	0	0	0	0	0	0	0	0	0	(435)	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	283	0	0	0	0	0	0	0	0	283	5
6	Maintenance	0	0	11,988	5,705	0	0	0	0	0	0	0	17,693	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(435)	0	15,900	5,705	0	21,170	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	61,282	0	0	0	0	0	0	0	0	0	61,282	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	61,282	0	0	0	0	0	0	0	0	0	61,282	16
	C. General Administration													
17	Administrative	0	(170,831)	10,058	0	0	0	0	0	0	0	0	(160,773)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(762)	0	19,343	0	0	0	0	0	0	0	0	18,581	19
20	Fees, Subscriptions & Promotions	(47,615)	0	0	0	0	0	0	0	0	0	0	(47,615)	20
21	Clerical & General Office Expenses	(82,284)	0	215,060	46	0	0	0	0	0	0	0	132,822	21
22	Employee Benefits & Payroll Taxes	0	0	22,587	218	0	0	0	0	0	0	0	22,805	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(125)	0	4,240	136	0	0	0	0	0	0	0	4,251	24
25	Other Admin. Staff Transportation	0	0	4,223	244	0	0	0	0	0	0	0	4,467	25
26	Insurance-Prop.Liab.Malpractice	0	2,410	3,649	88	0	0	0	0	0	0	0	6,147	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(130,786)	(168,421)	279,160	732	0	(19,315)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(131,221)	(107,139)	295,060	6,437	0	63,137	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Ctr Northbrook

0042341

Report Period Beginning:

7/1/07

Ending:

6/30/08

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

	Capital Expense	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)
	D. Ownership												
30	Depreciation	0	251,838	14,552	93	0	0	0	0	0	0	0	266,483 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(1,154,085)	778,870	0	0	0	0	0	0	0	0	0	(375,215) 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	(764,566)	20,128	0	0	0	0	0	0	0	0	(744,438) 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(1,154,085)	266,142	34,680	93	0	(853,170) 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
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(1,285,306)	159,003	329,740	6,530	0	(790,033) 45						

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	\$ 134,831	HSM Management Services, Inc.	0.00%	\$	\$(134,831) 1
2	V	17 Administration Fee	36,000	Midwest Administrative Services, Inc.	0.00%		(36,000) 2
3	V						
4	V	10a Therapy	112,774	Rosewood Therapy Services, Inc.	0.00%	174,056	61,282 4
5	V						
6	V	34 Rent	764,566	Northbrook Real Estate, Inc.	0.00%		(764,566) 6
7	V	30 Depreciation		Northbrook Real Estate, Inc.	0.00%	251,838	251,838 7
8	V	32 Interest		Northbrook Real Estate, Inc.	0.00%	778,870	778,870 8
9	V	26 Property Insurance		Northbrook Real Estate, Inc.	0.00%	2,410	2,410 9
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 1,048,171			\$ 1,207,174	\$ * 159,003 14

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

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	19 See Schedule VIII	\$	HSM Management Services Inc.		\$ 102	\$ 102	15
16	V	21 See Schedule VIII		HSM Management Services Inc.		46,344	46,344	16
17	V	22 See Schedule VIII		HSM Management Services Inc.		4,033	4,033	17
18	V	24 See Schedule VIII		HSM Management Services Inc.		2,499	2,499	18
19	V	25 See Schedule VIII		HSM Management Services Inc.		2,043	2,043	19
20	V	26 See Schedule VIII		HSM Management Services Inc.		1,249	1,249	20
21	V							21
22	V							22
23	V	1 See Schedule VIII		Midwest Administrative Services, Inc.		3,629	3,629	23
24	V	5 See Schedule VIII		Midwest Administrative Services, Inc.		283	283	24
25	V	6 See Schedule VIII		Midwest Administrative Services, Inc.		11,988	11,988	25
26	V	17 See Schedule VIII		Midwest Administrative Services, Inc.		10,058	10,058	26
27	V	19 See Schedule VIII		Midwest Administrative Services, Inc.		19,241	19,241	27
28	V	21 See Schedule VIII		Midwest Administrative Services, Inc.		168,716	168,716	28
29	V	22 See Schedule VIII		Midwest Administrative Services, Inc.		18,554	18,554	29
30	V	24 See Schedule VIII		Midwest Administrative Services, Inc.		1,741	1,741	30
31	V	25 See Schedule VIII		Midwest Administrative Services, Inc.		2,180	2,180	31
32	V	26 See Schedule VIII		Midwest Administrative Services, Inc.		2,400	2,400	32
33	V	30 See Schedule VIII		Midwest Administrative Services, Inc.		14,552	14,552	33
34	V	34 See Schedule VIII		Midwest Administrative Services, Inc.		20,128	20,128	34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 329,740	\$ * 329,740	39

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

Facility Name & ID Number Rosewood Care Ctr Northbrook # 0042341 Report Period Beginning: 7/1/07 Ending: 6/30/08

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	6 Repairs & Maintenance	\$	Senior Living Services		\$ 5,705	\$ 5,705	15
16	V	21 Clerical & Office Expenses		Senior Living Services		46	46	16
17	V	22 Payroll Taxes & Emp Benefits		Senior Living Services		218	218	17
18	V	24 Travel & Seminar		Senior Living Services		136	136	18
19	V	25 Other Admin Staff Transp		Senior Living Services		244	244	19
20	V	26 Insurance		Senior Living Services		88	88	20
21	V	30 Depreciation		Senior Living Services		93	93	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		\$			\$ 6,530	\$ * 6,530	39

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

Facility Name & ID Number Rosewood Care Ctr Northbrook # 0042341 Report Period Beginning: 7/1/07 Ending: 6/30/08

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	Larry Vander Maten	President	Management	75.00	79,593	3	7.60	Salary	\$ 6,550	17-8	1
2	Darrell Hoefling	Vice President	Management	25.00	46,634	3	7.60	Salary	3,508	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	\$ 10,058		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 Ctr Northbrook # 0042341 Report Period Beginning: 7/1/07 Ending: 6/30/08

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 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	19	Professional Services	Total Cost	46,341,843	18	\$ 1,305	\$ 3,635,792	\$ 102	1	
2	21	Salaries - Other	Total Cost	46,341,843	18	577,445	577,445	3,635,792	45,304	2
3	21	Taxes, Licenses & Ofc Sup	Total Cost	46,341,843	18	13,251	3,635,792	3,635,792	1,040	3
4	22	Payroll Taxes	Total Cost	46,341,843	18	34,692	3,635,792	3,635,792	2,722	4
5	22	Employee Benefits	Total Cost	46,341,843	18	16,704	3,635,792	3,635,792	1,311	5
6	24	Travel & Seminar	Total Cost	46,341,843	18	31,856	3,635,792	3,635,792	2,499	6
7	25	Other Admin Staff Transp	Total Cost	46,341,843	18	26,039	3,635,792	3,635,792	2,043	7
8	26	Insurance	Total Cost	46,341,843	18	15,926	3,635,792	3,635,792	1,249	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	TOTALS					\$ 717,218	\$ 577,445	\$	56,270	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr Northbrook # 0042341 Report Period Beginning: 7/1/07 Ending: 6/30/08

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 Midwest Administrative Services, Inc.
 Street Address 11701 Borman Drive, Suite 315
 City / State / Zip Code St. Louis, MO 63146
 Phone Number (314) 994-9070
 Fax Number (314) 994-9912

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Total Cost	18	\$ 47,734	\$ 47,734	7,232,064	\$ 3,629	1
2	5	Utilities	Total Cost	18	3,721		7,232,064	283	2
3	6	Maintenance	Total Cost	18	157,666		7,232,064	11,988	3
4	17	Salaries - Officers	Total Cost	18	132,286	132,286	7,232,064	10,058	4
5	19	Professional Fees	Total Cost	18	253,059		7,232,064	19,241	5
6	21	Salaries - Other	Total Cost	18	1,781,817	1,781,817	7,232,064	135,480	6
7	21	Clerical & Office Supplies	Total Cost	18	437,110		7,232,064	33,236	7
8	22	Payroll Taxes & Emp Ben.	Total Cost	18	244,016		7,232,064	18,554	8
9	24	Travel & Seminar	Total Cost	18	22,893		7,232,064	1,741	9
10	25	Other Admin. Transp	Total Cost	18	28,676		7,232,064	2,180	10
11	26	Insurance	Total Cost	18	31,565		7,232,064	2,400	11
12	30	Depreciation	Total Cost	18	172,574		7,232,064	13,122	12
13	34	Building Rent	Total Cost	18	264,718		7,232,064	20,128	13
14	17	Direct - Admin	Direct Cost	1			1		14
15	17	Direct - Admin	Direct Cost	17	107,457	107,457			15
16	30	Direct - Depreciation	Direct Cost	1	1,430		1	1,430	16
17	30	Direct - Depreciation	Direct Cost	17	20,150				17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,706,872	\$ 2,069,294		\$ 273,470	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr Northbrook # 0042341 Report Period Beginning: 7/1/07 Ending: 6/30/08

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	
						Original	Balance					
	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									
	A. Directly Facility Related											
	Long-Term											
1	Commerce Bank		X	Refinance Mortgage	Varies	09/05	\$ 12,500,000	\$ 12,500,000	12/15/08	LIBOR+1.	\$ 759,533	1
2	Interest Income										(17,627)	2
3	Amortization of Loan Fees										19,337	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 12,500,000	\$ 12,500,000			\$ 761,243	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 12,500,000	\$ 12,500,000			\$ 761,243	15

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

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 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,

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rosewood Care Ctr Northbrook COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042341

CONTACT PERSON REGARDING THIS REPORT Chuck Schmitz

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

A. Summary of Real Estate Tax Cos

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>04-06-101-007-0000</u>	<u>4101 Kingston Rd., Northbrook</u>	<u>\$ 128,504.06</u>	<u>\$ 128,504.06</u>
2. <u>04-06-101-006-0000</u>	<u>4101 Kingston Rd., Northbrook</u>	<u>\$ 117,496.15</u>	<u>\$ 117,496.15</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>246,000.21</u>	\$ <u>246,000.21</u>

B. Real Estate Tax Cost Allocation:

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 63,834 B. General Construction Type: Exterior Brick Veneer Frame Steel Number of Stories 2

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 ground (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>6.6 Acres</u>	<u>1998</u>	<u>\$ 1,313,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	#VALUE!		\$ 1,313,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr Northbrook

0042341

Report Period Beginning:

7/1/07

Ending:

6/30/08

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	147		1998	\$ 8,660,744	\$	25-40	\$ 236,043	\$ 236,043	\$ 2,361,490	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Fence Installation		1998	1,900		7			1,900	9
10	Patient Monitoring System		1998	54,214		7			54,214	10
11	Signs		1998	21,364		7			21,364	11
12	Cabinets		1998	11,679		7			11,679	12
13	Drains		1998	3,833		7			3,833	13
14	Stone Pavers		1998	9,661		7			9,661	14
15	Handicap Rails		1998	23,313		7			23,313	15
16	Sprinkler Water Pumps		1998	37,340		7			37,340	16
17	Generator		1998	74,806		7			74,806	17
18	Security monitoring System		1998	22,221		7			22,221	18
19	Paging Systems		1998	46,099		7			46,099	19
20	Plumbing for Lawn Irrigation		1998	12,549		7			12,549	20
21	Run Conduit Wire		2003	7,350		40	184	184	919	21
22	Seal and Restripe Parking Lot		2003	5,635		25	226	226	1,108	22
23	Heating Coils		2005	8,677		10	868	868	2,603	23
24	Sump Pump		2006	2,634		10	263	263	658	24
25	Heat Pumps		2006	3,447		10	345	345	805	25
26	Sidewalk along Lake		2007	3,975		40	25	25	25	26
27	Rooftop Exhaust Fans		2007	3,183		10	212	212	212	27
28	Motor for Exhaust Fan		2007	4,141		10	242	242	242	28
29	Floor Tile		2007	7,361		10	429	429	429	29
30	Rebuild Generator		2007	24,684		10	1,851	1,851	1,851	30
31	Cooling Coil		2007	14,814		10	988	988	988	31
32	Seal Coat Parking Lot		2007	4,494		25	105	105	105	32
33	VCT Tile		2008	4,131		10	69	69	69	33
34	Heat Pump Parts		2008	5,111		10	128	128	128	34
35										35
36	Continued on Next Page									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 Ctr Northbrook

0042341

Report Period Beginning:

7/1/07

Ending:

6/30/08

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	Facility Leaseholds:								37
38	Computer Cabling	2001	3,230	231	7	231		3,230	38
39	TV Lounge Carpet	2002	2,870	410	7	410		2,597	39
40	Carpet	2002	3,104	443	7	443		2,624	40
41	Concrete Floor Coating	2005	3,300	471	7	471		1,454	41
42	Painting	2006	3,440	491	7	491		1,147	42
43	Carpeting	2006	7,137	1,020	7	1,020		1,954	43
44	Replace Tiling	2006	4,600	657	7	657		1,314	44
45	New Flooring in Lobby, TV Lounge, Offices, & Conference Room	2007	9,110	1,085	7	1,085		1,085	45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 9,116,151	\$ 4,808		\$ 246,786	\$ 241,978	\$ 2,706,016	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 Ctr Northbrook # 0042341 Report Period Beginning: 7/1/07 Ending: 6/30/08

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	\$ 223,262	\$	\$ 17,254	\$ 17,254	5-10 Yrs	\$ 151,947	71
72	Current Year Purchases	4,254		338	338	5-10 Yrs	338	72
73	Fully Depreciated Assets	369,981					369,981	73
74								74
75	TOTALS	\$ 597,497	\$	\$ 17,592	\$ 17,592		\$ 522,266	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	\$ 29,468	\$	\$ 6,821	\$ 6,821	4 Yrs	\$ 10,987	76
77	Senior Living Services	Various	Various	371		93	93	4 Yrs	182	77
78										78
79										79
80	TOTALS			\$ 29,839	\$	\$ 6,914	\$ 6,914		\$ 11,169	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)	\$ 11,056,487	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 4,808	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 271,292	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 266,484	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,239,451	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.

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? YES NO

If NO, see instructions.

	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.	<u>/2009</u>	\$ _____
13.	<u>/2010</u>	\$ _____
14.	<u>/2011</u>	\$ _____

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.

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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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			Total
		1 Drop-outs	2 Completed	3 Contract	
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)	\$			

- (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.

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	

- (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	1 Schedule V Line & Column Reference	3 Staff		5 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			2 Units of Service	3 Cost	4					
					Units	Cost				
1	Licensed Occupational Therapist	10a-8	hrs	\$	13,052	\$ 232,075	\$	13,052	\$ 232,075	1
2	Licensed Speech and Language Development Therapist	10a-8	hrs		4,056	90,142		4,056	90,142	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-8	hrs		14,916	227,280	1,218	14,916	228,498	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				146,604		146,604	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Ambulance, Laboratory, Enterals Other (specify): <u>& X-Ray</u>	39-8				18,291	13,183		31,474	13
14	TOTAL			\$	32,024	\$ 567,788	\$ 161,005	32,024	\$ 728,793	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

STATE OF ILLINOIS

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Facility Name & ID Number Rosewood Care Ctr Northbrook

0042341

Report Period Beginning: 7/1/07

Ending:

6/30/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/08

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 348,757	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 100,000)	2,296,571		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,545		6
7	Other Prepaid Expenses	57,018		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,704,891	\$	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	36,791		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(15,404)		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)	\$ 21,387	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,726,278	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 231,434	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	16,578,457		29
30	Accrued Salaries Payable	283,972		30
31	Accrued Taxes Payable (excluding real estate taxes)	15,707		31
32	Accrued Real Estate Taxes(Sch.IX-B)	302,747		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	500		35
	Other Current Liabilities(specify):			
36	Accrued Interest - Related Party	1,588,120		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 19,000,937	\$	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)	\$ 19,000,937	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (16,274,659)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,726,278	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (15,369,483)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (15,369,483)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(905,176)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (905,176)	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)	\$ (16,274,659)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Rosewood Care Ctr Northbrook

0042341

Report Period Beginning: 7/1/07

Ending:

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6/30/08

VII. 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	\$ 7,199,655	1
2	Discounts and Allowances for all Levels	(1,114,006)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,085,649	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,208,605	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,208,605	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	3,300	13
14	Non-Patient Meals	225	14
15	Telephone, Television and Radio	70	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)	\$ 3,595	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	17,627	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 17,627	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	850	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 850	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,316,326	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,268,921	31
32	Health Care	3,562,468	32
33	General Administration	1,099,949	33
B. Capital Expense			
34	Ownership	2,034,533	34
C. Ancillary Expense			
35	Special Cost Centers	178,078	35
36	Provider Participation Fee	77,553	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,221,502	40
41	Income before Income Taxes (line 30 minus line 40)**	(905,176)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (905,176)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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 Ctr Northbrook

0042341

Report Period Beginning: 7/1/07

Ending: 6/30/08

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	2,031	2,151	\$ 74,475	\$ 34.62	1
2	1,479	1,567	52,520	33.52	2
3	27,709	29,353	1,049,932	35.77	3
4	8,992	9,526	237,991	24.98	4
5	85,329	90,392	1,128,014	12.48	5
6					6
7					7
8	4,022	4,261	106,501	24.99	8
9					9
10	5,180	5,487	63,453	11.56	10
11	2,840	3,008	42,891	14.26	11
12					12
13					13
14					14
15	23,832	25,246	280,486	11.11	15
16					16
17	2,264	2,398	38,753	16.16	17
18	18,623	19,728	173,649	8.80	18
19	5,841	6,188	58,896	9.52	19
20	2,052	2,174	108,122	49.73	20
21					21
22					22
23					23
24	12,522	13,265	200,536	15.12	24
25					25
26					26
27					27
28					28
29					29
30					30
31	2,465	2,611	35,510	13.60	31
32					32
33					33
34	205,181	217,355	\$ 3,651,729 *	\$ 16.80	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	Contract	\$ 7,773	1-3	35
36	Contract	9,140	9-3	36
37				37
38				38
39	Contract	1,029	10-3	39
40				40
41				41
42				42
43				43
44	Contract	2,156	11-3	44
45	Contract	1,026	12-3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 21,124		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	1,250	\$ 62,797	10-3	50
51	603	25,002	10-3	51
52	0	0	10-3	52
53	1,853	\$ 87,799		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
1	Schedule Not Applicable		\$		\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political 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. \$ 80,719 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. \$ 77,553
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 benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 225
- (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 NORTHBROOK, INC.
IDPH ID #0042341
ATTACHMENT TO SCHEDULE XIX, Section C
6/30/2008

PROFESSIONAL SERVICES:

<u>VENDOR/PAYEE</u>	<u>TYPE</u>	<u>AMOUNT</u>
C.J. Schlosser & Co.	Accountant/Consultant	4,200
Daniel Maher	Legal	8,148
Kelly Olsen	Legal	4,109
Larson Allen	Accountant/Consultant	1,728
Myers, Miller	Legal	7,396
Nelson Brothers		50
Old Republic Surety Group	Surety Bond	50
Summer, Compton, Wells & Hamburg	Legal	1,635
Theresa Counts Burke	Legal	762
Urban Real Estate	Consultant	5,000
Total		<u><u>\$33,078</u></u>

ROSEWOOD CARE CENTER OF NORTHBROOK
IDPH ID #0042341
ATTACHMENT TO SCHEDULE V, LINE 25
6/30/2008

OTHER ADMIN. STAFF TRANSPORTATION:

MILEAGE REIMBURSEMENT**	<u>\$ 4,600</u>
	<u>\$ 4,600</u>

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

ROSEWOOD CARE CENTER OF NORTHBROOK
IDPH ID #0042341
ATTACHMENT TO SCHEDULE VII, SECTION A
6/30/2008

RELATED NURSING HOME:

CITY:

ROSEWOOD CARE CENTER OF ALTOM	ALTON, IL
ROSEWOOD CARE CENTER OF EAST PEORIA	EAST PEORIA, IL
ROSEWOOD CARE CENTER OF EDWARDSVILLE	EDWARDSVILLE, IL
ROSEWOOD CARE CENTER OF ELGIN	ELGIN, IL
ROSEWOOD CARE CENTER OF GALESBURG	GALESBURG, IL
ROSEWOOD CARE CENTER OF INVERNESS	INVERNESS, IL
ROSEWOOD CARE CENTER OF JOLIET	JOLIET, IL
ROSEWOOD CARE CENTER OF MOLINE	MOLINE, IL
ROSEWOOD CARE CENTER OF 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.
NORTHBROOK REAL ESTATE, INC.	REAL ESTATE LSG.
RCC HOLDING COMPANY	HOLDING COMPANY
ROSEWOOD HOME HEALTH	HOME HEALTH CO.
ROSEWOOD THERAPY SERVICES	THERAPY COMPANY
SENIOR LIVING SERVICES, INC.	BLDG SERVICES CO.