

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR# 0041780 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>55</u>	Skilled (SNF)	<u>55</u>	<u>20,075</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>55</u>	Intermediate (ICF)	<u>55</u>	<u>20,075</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>110</u>	TOTALS	<u>110</u>	<u>40,150</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			<u>2,537</u>	<u>2,537</u>	8
9	SNF/PED					9
10	ICF	<u>28,365</u>	<u>3,897</u>		<u>32,262</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>28,365</u>	<u>3,897</u>	<u>2,537</u>	<u>34,799</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.67%

D. How many bed-hold days during this year were paid by Public Aid?

276 (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)

NONEF. 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 03/01/96

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

YES Date 03/01/96 NO

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

YES NO If YES, enter number of beds certified 24 and days of care provided 2,537Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

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

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	184,883	16,539	4,189	205,611		205,611		205,611		1
2	Food Purchase		133,360		133,360	(12,593)	120,767	(702)	120,065		2
3	Housekeeping	96,625	20,393		117,018		117,018		117,018		3
4	Laundry	32,176	12,376		44,552		44,552		44,552		4
5	Heat and Other Utilities			61,971	61,971		61,971	294	62,265		5
6	Maintenance	34,808	16,737	25,384	76,929		76,929	9,466	86,395		6
7	Other (specify):*			7,396	7,396		7,396		7,396		7
8	TOTAL General Services	348,492	199,405	98,940	646,837	(12,593)	634,244	9,058	643,302		8
	B. Health Care and Programs										
9	Medical Director			5,400	5,400		5,400		5,400		9
10	Nursing and Medical Records	973,477	65,390	1,140	1,040,007		1,040,007	22,759	1,062,766		10
10a	Therapy	33,967	9,773	84,428	128,168		128,168	(748)	127,420		10a
11	Activities	34,480	2,025		36,505		36,505		36,505		11
12	Social Services	24,290		4,593	28,883		28,883		28,883		12
13	Nurse Aide Training										13
14	Program Transportation			800	800		800		800		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,066,214	77,188	96,361	1,239,763		1,239,763	22,011	1,261,774		16
	C. General Administration										
17	Administrative	80,370			80,370		80,370	37,508	117,878		17
18	Directors Fees										18
19	Professional Services			193,810	193,810		193,810	(143,555)	50,255		19
20	Dues, Fees, Subscriptions & Promotions			16,608	16,608		16,608	(5,682)	10,926		20
21	Clerical & General Office Expenses	131,023	7,784	104,521	243,328		243,328	(12,020)	231,308		21
22	Employee Benefits & Payroll Taxes			189,858	189,858	12,593	202,451		202,451		22
23	Inservice Training & Education							710	710		23
24	Travel and Seminar			1,242	1,242		1,242	285	1,527		24
25	Other Admin. Staff Transportation			2,936	2,936		2,936	2,006	4,942		25
26	Insurance-Prop.Liab.Malpractice			103,930	103,930		103,930	3,018	106,948		26
27	Other (specify):*							27,876	27,876		27
28	TOTAL General Administration	211,393	7,784	612,905	832,082	12,593	844,675	(89,854)	754,821		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,626,099	284,377	808,206	2,718,682		2,718,682	(58,785)	2,659,897		29

*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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			4,500	4,500		4,500	124,095	128,595			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			49,538	49,538		49,538	190,596	240,134			32
33	Real Estate Taxes			56,193	56,193		56,193		56,193			33
34	Rent-Facility & Grounds			372,105	372,105		372,105	(366,125)	5,980			34
35	Rent-Equipment & Vehicles			53,653	53,653		53,653	(3,623)	50,030			35
36	Other (specify):*											36
37	TOTAL Ownership			535,989	535,989		535,989	(55,057)	480,932			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		92,242	119,812	212,054		212,054	(20,147)	191,907			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			60,225	60,225		60,225		60,225			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		92,242	180,037	272,279		272,279	(20,147)	252,132			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,626,099	376,619	1,524,232	3,526,950		3,526,950	(133,989)	3,392,961			45

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

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	OHF 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	1,375	30		9
10	Interest and Other Investment Income	(18,025)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(702)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(4,255)	21		18
19	Entertainment		20		19
20	Contributions	(400)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(4,840)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(1,835)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(5,198)	20		28
29	Other-Attach Schedule SEE PAGE 5A	1,557			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (32,323)		\$	30

OHF 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)	(101,666)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (101,666)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (133,989)		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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS
ROSE GARDEN CONVALESCENT CTR

ID# 0041780

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	DEFERRED MAINTENANCE	\$ 1,557	6	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	1,557		48
49				49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR

0041780

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

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	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(702)	0	0	0	0	0	0	0	0	0	0	(702)	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	294	0	0	0	0	0	0	0	0	294	5
6	Maintenance	1,557	0	7,909	0	0	0	0	0	0	0	0	9,466	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	855	0	8,203	0	9,058	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	22,759	0	0	0	0	0	0	0	0	22,759	10
10a	Therapy	0	(6,980)	6,232	0	0	0	0	0	0	0	0	(748)	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	Nurse Aide 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	(6,980)	28,991	0	22,011	16							
	C. General Administration													
17	Administrative	0	0	37,508	0	0	0	0	0	0	0	0	37,508	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(4,840)	(144,000)	5,285	0	0	0	0	0	0	0	0	(143,555)	19
20	Fees, Subscriptions & Promotions	(7,433)	0	1,751	0	0	0	0	0	0	0	0	(5,682)	20
21	Clerical & General Office Expenses	(4,255)	(66,000)	58,235	0	0	0	0	0	0	0	0	(12,020)	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	710	0	0	0	0	0	0	0	0	710	23
24	Travel and Seminar	0	0	285	0	0	0	0	0	0	0	0	285	24
25	Other Admin. Staff Transportation	0	0	2,006	0	0	0	0	0	0	0	0	2,006	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,018	0	0	0	0	0	0	0	0	3,018	26
27	Other (specify):*	0	0	27,876	0	0	0	0	0	0	0	0	27,876	27
28	TOTAL General Administration	(16,528)	(210,000)	136,674	0	(89,854)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(15,673)	(216,980)	173,868	0	(58,785)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR

0041780

Report Period Beginning:

01/01/2002 Ending:

12/31/2002

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	1,375	113,235	9,485	0	0	0	0	0	0	0	0	124,095	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(18,025)	185,348	23,273	0	0	0	0	0	0	0	0	190,596	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(372,105)	5,980	0	0	0	0	0	0	0	0	(366,125)	34
35	Rent-Equipment & Vehicles	0	(9,163)	5,540	0	0	0	0	0	0	0	0	(3,623)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(16,650)	(82,685)	44,278	0	(55,057)	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	(20,147)	0	0	0	0	0	0	0	0	0	(20,147)	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	(20,147)	0	0	0	0	0	0	0	0	0	(20,147)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(32,323)	(319,812)	218,146	0	(133,989)	45							

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR

0041780

Report Period Beginning: 01/01/2002 Ending: 12/31/2002

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
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		CARE PLUS MGMT		
				ROSE GARDEN CARE CENTER LLC		
					NILES	
				CARE PLUS MGMT		
				ROSE GARDEN CARE CENTER LLC		
					NILES	

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		\$	CAREPLUS MGMT INC.		\$	\$	1
2	V	19 ADMIN. CONSULTANT FEES	132,000	" " "			(132,000)	2
3	V	19 DATA PROCESSING FEES	12,000	" " "			(12,000)	3
4	V	21 CLERICAL FEES	66,000	" " "			(66,000)	4
5	V	35 COMPUTER LEASE	9,163	" " "			(9,163)	5
6	V							6
7	V	34 RENT	372,105	ROSE GARDEN CARE CENTER LLC			(372,105)	7
8	V	30 SL DEPRECIATION		" " "		113,235	113,235	8
9	V	32 INTEREST		" " "		185,348	185,348	9
10	V							10
11	V							11
12	V	10a THERAPY SERVICES	51,281	CAREPLUS REHABILITATIVE SERVICES		44,301	(6,980)	12
13	V	39 ANCILLARY THERAPY	148,030	" " "		127,883	(20,147)	13
14	Total		\$ 790,579			\$ 470,767	\$ * (319,812)	14

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

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR# 0041780Report Period Beginning: 01/01/2002 Ending: 12/31/2002

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	1	DIETARY SALARIES	\$	CAREPLUS MGMT INC.		\$	\$	15
16	V	5	ELECTRICITY		" " "		294	294	16
17	V	6	MAINT & REPAIRS		" " "		698	698	17
18	V	6	MAINTENANCE SALARIES		" " "		7,211	7,211	18
19	V	10	NURSING SALARIES		" " "		22,759	22,759	19
20	V	10a	THERAPY SUPPLIES/SVC		" " "		202	202	20
21	V	10a	THERAPY SALARIES		" " "		6,030	6,030	21
22	V	17	ADMIN SALARIES		" " "		37,508	37,508	22
23	V	19	PROFESSIONAL FEES		" " "		5,285	5,285	23
24	V	20	ADVERTISING		" " "		1,751	1,751	24
25	V	21	OFFICE EXPENSE		" " "		14,607	14,607	25
26	V	21	OFFICE SALARIES		" " "		43,628	43,628	26
27	V	23	SEMINARS		" " "		710	710	27
28	V	24	TRAVEL		" " "		285	285	28
29	V	25	TRANSPORTATION		" " "		2,006	2,006	29
30	V	26	INSURANCE		" " "		3,018	3,018	30
31	V	27	EMPLOYEE BENEFITS		" " "		27,876	27,876	31
32	V	30	DEPRECIATION		" " "		9,485	9,485	32
33	V	32	INTEREST		" " "		23,273	23,273	33
34	V	34	OFFICE RENT		" " "		5,980	5,980	34
35	V	35	EQUIPMENT RENT		" " "		5,540	5,540	35
36	V								36
37	V								37
38	V								38
39	Total		\$				\$ 218,146	\$ * 218,146	39

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

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

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	CAREPLUS MGMT ALLOCATIONS:							\$		1	
2	JACOB BAKST	DIR OF OPERATIO	ADMIN,CONSUL		SEE ATTACHED			SALARY	11,104	17-7	2
3	SHERWIN I. RAY	PRESIDENT	ADMIN,FINANCE		SCHEDULES			"	11,104	17-7	3
4	JOE ZIMMERMAN	CFO	FINANCIAL		" "			"	7,164	17-7	4
5	JANICE CLAFFORD	CONTROLLER	CLERICAL		" "			"	3,044	17-7	5
6	ROMY MACASAET	RN CONSULTANT	NURSING		" "			"	5,104	17-7	6
7	JAMEE O'BRIEN	REGIONAL MGMT	ADMINISTRATION		" "			"	6,513	17-7	7
8	TAMMY ORR	RN CONSULTANT	NURSING		" "			"	5,821	17-7	8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 49,854		13

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

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

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

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 CAREPLUS MGMT
 Street Address 5940 W. TOUHY
 City / State / Zip Code NILES, IL 60714
 Phone Number (847) 647-1717
 Fax Number (847) 647-0222

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 SALARIES	PATIENT DAYS	579,760	13	\$ 75,722	\$ 75,722	\$ 0	1
2	5	ELECTRICITY	" "	579,760	13	4,894	34,799	294	2
3	6	MAINT & REPAIRS	" "	579,760	13	11,630	34,799	698	3
4	6	MAINTENANCE SALARIES	" "	579,760	13	120,135	34,799	7,211	4
5	10	NURSING SALARIES	" "	579,760	13	379,168	34,799	22,759	5
6	10a	THERAPY SUPPLIES/SVC	" "	579,760	13	3,372	34,799	202	6
7	10a	THERAPY SALARIES	" "	579,760	13	100,459	34,799	6,030	7
8	17	ADMIN SALARIES	" "	579,760	13	624,886	34,799	37,508	8
9	19	PROFESSIONAL FEES	" "	579,760	13	88,050	34,799	5,285	9
10	20	ADVERTISING	" "	579,760	13	29,166	34,799	1,751	10
11	21	OFFICE EXPENSE	" "	579,760	13	243,348	34,799	14,607	11
12	21	OFFICE SALARIES	" "	579,760	13	726,859	34,799	43,628	12
13	23	SEMINARS	" "	579,760	13	11,834	34,799	710	13
14	24	TRAVEL	" "	579,760	13	4,741	34,799	285	14
15	25	TRANSPORTATION	" "	579,760	13	33,425	34,799	2,006	15
16	26	INSURANCE	" "	579,760	13	50,288	34,799	3,018	16
17	27	EMPLOYEE BENEFITS	" "	579,760	13	464,414	34,799	27,876	17
18	30	DEPRECIATION	" "	579,760	13	158,032	34,799	9,485	18
19	32	INTEREST	" "	579,760	13	387,734	34,799	23,273	19
20	34	OFFICE RENT	" "	579,760	13	99,626	34,799	5,980	20
21	35	EQUIPMENT RENT	" "	579,760	13	92,291	34,799	5,540	21
22									22
23									23
24									24
25	TOTALS					\$ 3,710,074	\$ 2,027,229	\$ 218,146	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	RELATED PARTY: ROSE GARDEN CENTER LLC									1										
2	AMERICAN NATIONAL BANK	X	MORTGAGE	\$28,571.00	09/98	3,600,000	3,197,894	08/2018	7.2100	179,727										
3	CIB	X	CAPITAL IMPRV LOAN			90,000	59,741			5,621										
4										4										
5										5										
Working Capital																				
6										6										
7	SHAREHOLDER/PARTNER	X	WORKING CAPITAL				540,000			49,538										
8										8										
9	TOTAL Facility Related			\$28,571.00		\$ 3,690,000	\$ 3,797,635			\$ 234,886										
B. Non-Facility Related*																				
10										10										
11										11										
12										12										
13										13										
14	TOTAL Non-Facility Related					\$	\$			\$										
15	TOTALS (line 9+line14)					\$ 3,690,000	\$ 3,797,635			\$ 234,886										

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

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR# 0041780 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	53,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	53,993	2
3. Under or (over) accrual (line 2 minus line 1).			\$	993	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	55,200	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	56,193	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1997	<u>27,457</u>	8	
		1998	<u>31,199</u>	9	
		1999	<u>50,679</u>	10	
		2000	<u>51,837</u>	11	
		2001	<u>53,993</u>	12	
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL.					
THE PAYMENT ON LINE 2 APPLIES TO THE 2001 TAX BILL.					
FOR OHF USE ONLY					
13	FROM R. E. TAX STATEMENT FOR 2001	\$			13
14	PLUS APPEAL COST FROM LINE 5	\$			14
15	LESS REFUND FROM LINE 6	\$			15
16	AMOUNT TO USE FOR RATE CALCULATION	\$			16

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2001 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 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 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,

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ROSE GARDEN CONVALESCENT CTR COUNTY PEORIA

FACILITY IDPH LICENSE NUMBER 0041780

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2001 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 2001

(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>53,992.72</u>	\$ <u>53,992.72</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>53,992.72</u>	\$ <u>53,992.72</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 direct 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 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>NURSING HOME</u>	<u>400,860</u>	<u>1998</u>	<u>\$ 126,500</u>	1
2					2
3	TOTALS	400,860		\$ 126,500	3

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

0041780

Report Period Beginning:

01/01/2002 Ending:

12/31/2002

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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		RELATED PARTY: ROSE GARDEN CARE CENTER LLC			\$	\$		\$	\$	\$	4
5	110		1998		2,536,069	65,025	39	65,025		279,095	5
6					884,255	22,672	39	22,672		154,009	6
7											7
8						71		71			8
		Improvement Type**									
9		COOLER DOOR		1996	1,675	43	39	43		335	9
10		LIGHTING		1997	2,293	59	39	59		410	10
11		PARKING LOT REPAIRS		1998	3,628	242	15	242		1,331	11
12		BUMPERS/HANDRAILS/ORNAMENTAL RAILING		1999	17,449	447	39	447		1,907	12
13		CARPET		2000	2,677	97	27.5	97		214	13
14		FENCING		2001	1,513	55	27.5	55		76	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

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

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,449,559	\$ 88,711		\$ 88,711	\$	\$ 437,377	70

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

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

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	\$ 29,950	\$ 4,500	\$ 2,896	\$ (1,604)		\$ 10,550	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	<u>RELATED PARTY</u>	<u>275,745</u>	<u>34,009</u>	<u>36,988</u>	<u>2,979</u>			74
75	TOTALS	\$ 305,695	\$ 38,509	\$ 39,884	\$ 1,375		\$ 10,550	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)	\$ 3,881,754	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 127,220	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 128,595	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,375	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 447,927	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: NA

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 Date of Lease	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>/2003</u>	\$ _____
13.	<u>/2004</u>	\$ _____
14.	<u>/2005</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: \$ 53,653 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

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

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

<p>1. HAVE YOU TRAINED AIDES 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>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</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 AIDE _____</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 AIDE _____</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	Nurse Aide 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 aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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	39-3	hrs	\$		\$ 51,696	\$		\$ 51,696	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			730			730	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			61,217			61,217	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				88,262		88,262	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): LAB,RENTAL,SUPP	39-2					10,149		10,149	13
14	TOTAL			\$		\$ 113,643	\$ 98,411		\$ 212,054	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 nurse aides, who help with the above activities should not be listed on this schedule.

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,457,220		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	50,932		6
7	Other Prepaid Expenses	2,237		7
8	Accounts Receivable (owners or related parties)	405,751		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,916,140	\$	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			15
16	Equipment, at Historical Cost	29,950		16
17	Accumulated Depreciation (book methods)	(21,729)		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)	\$ 8,221	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,924,361	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 481,800	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,765		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	74,287		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,300		31
32	Accrued Real Estate Taxes(Sch.IX-B)	55,200		32
33	Accrued Interest Payable	115,588		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 736,940	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	592,999		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)	\$ 592,999	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,329,939	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 594,422	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,924,361	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 278,094	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 278,094	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	\$ 316,328	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)	\$ 316,328	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)	\$ 594,422	24 *

* This must agree with page 17, line 47.

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

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,818,537	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,818,537	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	6,716	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 6,716	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide 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		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)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	18,025	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 18,025	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,843,278	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	646,837	31
32	Health Care	1,239,763	32
33	General Administration	832,082	33
B. Capital Expense			
34	Ownership	535,989	34
C. Ancillary Expense			
35	Special Cost Centers	212,054	35
36	Provider Participation Fee	60,225	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,526,950	40
41	Income before Income Taxes (line 30 minus line 40)**	316,328	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 316,328	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.

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

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR

0041780

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

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	1,798	2,060	\$ 46,584	\$ 22.61	1
2	Assistant Director of Nursing	1,881	1,897	42,075	22.18	2
3	Registered Nurses	4,157	4,491	104,760	23.33	3
4	Licensed Practical Nurses	16,615	17,754	313,825	17.68	4
5	Nurse Aides & Orderlies	42,776	46,308	466,233	10.07	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,774	2,987	33,967	11.37	8
9	Activity Director					9
10	Activity Assistants	4,612	4,767	34,480	7.23	10
11	Social Service Workers	1,952	2,086	24,290	11.64	11
12	Dietician					12
13	Food Service Supervisor	3,993	4,230	56,237	13.29	13
14	Head Cook	5,993	6,489	42,474	6.55	14
15	Cook Helpers/Assistants	9,230	11,377	86,172	7.57	15
16	Dishwashers					16
17	Maintenance Workers	3,119	3,313	34,808	10.51	17
18	Housekeepers	11,746	12,691	96,625	7.61	18
19	Laundry	5,653	6,016	32,176	5.35	19
20	Administrator	2,008	2,372	72,287	30.48	20
21	Assistant Administrator	280	316	8,083	25.58	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,923	10,689	131,023	12.26	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	128,510	139,843	\$ 1,626,099 *	\$ 11.63	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		\$ 4,189	1-3	35
36	Medical Director		5,400	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant		1,140	10-3	39
40	Physical Therapy Consultant		5,400	10a-3	40
41	Occupational Therapy Consultant		5,400	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant		4,593	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 26,122		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$		53

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY1999	6 FY2000	7 FY2001	8 FY2002	9 FY2003	10 FY2004	11 FY2005	12 FY2006	13 FY2007
1	PAINTING/DECORATING	2000	\$ 4,671	3	\$	\$ 779	\$ 1,557	\$ 1,557	\$ 778	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
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11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 4,671		\$	\$ 779	\$ 1,557	\$ 1,557	\$ 778	\$	\$	\$	\$

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 LONG TERM CARE \$ 5742
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (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? _____
- (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 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 754 Line 10-2
- (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 of Public Aid during this cost report period. \$ 60,225
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 of Public Aid, 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. \$ 12,593 Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
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. \$ _____
- (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 \$2500, 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.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	4,189
	REPAIRS & MAINTENANCE	0
		0
		4,189
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	21,203
	ELECTRICITY	31,516
	WATER	8,648
	CABLE TV - LOBBY	604
		0
		61,971
6	MAINTENANCE	
	GROUNDS MAINTENANCE	6,266
	PAINTING & DECORATING	738
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	14,142
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	2,640
	FIRE SERVICE	1,598
		0
		0
		0
		25,384
7	OTHER	
	SCAVENGER	7,396
	SECURITY SERVICE	0
		0
		7,396
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	5,400
		5,400

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B -2	0
	RESTORATIVE NURSING CONSULTAN XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	1,140
	UTILIZATION REVIEW FEES XVIII B -2	0
	PHYSICIANS XVIII B -2	0
	PSYCHIATRIC XVIII B -2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		1,140
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	34,290
	SPEECH THERAPY SERVICES	1,432
	OCCUPATIONAL THERAPY SERVICES	26,290
	THERAPY CONTRACT SERVICES	11,616
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	5,400
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	5,400
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		84,428
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	4,593
	SOCIAL WORKER XVIII B 45-2	0
		0
		4,593
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	800
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	0
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	16,912
	ADMINISTRATIVE CONSULTANTS XIX C	132,000
	PROFESSIONAL FEES XIX C	44,898
		0
		193,810
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	1,835
	EMPLOYEE WANT ADS XIX F	2,318
	CONTRIBUTIONS VI 20 XIX F	400
	DUES & SUBSCRIPTIONS XIX F	6,342
	LICENSES & PERMITS XIX F	515
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	5,198
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
		16,608
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES	10,511
	EQUIPMENT REPAIR & MAINTENANCE	7,505
	OUTSIDE CLERICAL SERVICES	66,000
	PENALTIES / OVERDRAFT CHARGES VI 18	4,255
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	14,533
	MESSENGER SERVICE	1,717
		0
		104,521

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	123,472
	UNEMPLOYMENT COMPENSATION XIX D	14,976
	WORKERS COMPENSATION INSURANC XIX D	44,729
	HOSPITALIZATION INSURANCE XIX D	4,856
	EMPLOYEE BENEFITS - OTHER XIX D	1,598
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	227
	CHICAGO HEAD TAX XIX D	0
		189,858
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	1,034
	TRAVEL XIX G	208
		0
		0
		1,242
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	2,936
		2,936
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	103,930
		103,930
27	OTHER	
	BAD DEBTS VI 24	0
		0
		0

GRAND TOTAL COLUMN 3 OTHER

808,206

ROSE GARDEN CONVALESCENT CTR
 EMPLOYEE MEAL RECLASSIFICATION
 12/31/2002

TOTAL FOOD PURCHASE	133,360	PATIENT MEALS	104397
LESS SALES TAX	(702)	ADD EMPLOYEE MEALS	10950
	-----		-----
NET FOOD	132,658	TOTAL MEALS/YEAR	115347
TOTAL PATIENT CENSUS	34,799	NET FOOD	132658
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	115347

TOTAL PATIENT MEALS	104397	COST PER MEAL	1.15
		TIME EMPLOYEE MEALS	10950
ADD # EMPLOYEE MEALS/DAY	30		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	12593
	-----		=====
TOTAL EMPLOYEE MEALS	10950		