

		FOR OHF USE				

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0041756</u></p> <p>Facility Name: <u>Rosewood Care Center Rockford</u></p> <p>Address: <u>1660 South Mulford Road</u> <u>Rockford</u> <u>61108</u> Number City Zip Code</p> <p>County: <u>Winnebago</u></p> <p>Telephone Number: <u>(815) 397-8700</u> Fax # ()</p> <p>IDPA ID Number: <u>041756</u></p> <p>Date of Initial License for Current Owners: <u>5/20/96</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Cindy A. Tefeller</u> Telephone Number: <u>(618) 465-7717</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/2001</u> to <u>6/30/2002</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) <u>Accountant's Compilation Report Attached</u> (Date) _____ (Print Name and Title) <u>Cindy A. Tefeller</u> (Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 East Center Drive, Alton, IL 62002</u> (Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u></td> </tr> </table> <p align="center">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) <u>Accountant's Compilation Report Attached</u> (Date) _____ (Print Name and Title) <u>Cindy A. Tefeller</u> (Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 East Center Drive, Alton, IL 62002</u> (Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
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SEE ACCOUNTANT'S COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Rockford

0041756 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

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>120</u>	Skilled (SNF)	<u>120</u>	<u>43,800</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>120</u>	TOTALS	<u>120</u>	<u>43,800</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other		Total
8	SNF			<u>13,532</u>	<u>13,532</u>	8
9	SNF/PED					9
10	ICF	<u>6,849</u>	<u>12,873</u>		<u>19,722</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>6,849</u>	<u>12,873</u>	<u>13,532</u>	<u>33,254</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.92%

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

21 (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 5/20/96

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

YES Date 5/20/96 NO

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

YES NO If YES, enter number of beds certified 58 and days of care provided 13,532

Medicare Intermediary Tri-Span

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/2002 Fiscal Year: 6/30/2002

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

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Rosewood Care Center Rockford # 0041756 Report Period Beginning: 7/1/2001 Ending: 6/30/2002**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	183,242	16,466	11,347	211,055		211,055		211,055		1
2	Food Purchase		139,768		139,768		139,768	(7,009)	132,759		2
3	Housekeeping	118,628	22,926		141,554		141,554		141,554		3
4	Laundry	34,478	19,099		53,577		53,577		53,577		4
5	Heat and Other Utilities			101,783	101,783		101,783	420	102,203		5
6	Maintenance	26,648	11,793	65,386	103,827		103,827	17,613	121,440		6
7	Other (specify):* Sanitation Services			12,700	12,700		12,700		12,700		7
8	TOTAL General Services	362,996	210,052	191,216	764,264		764,264	11,024	775,288		8
	B. Health Care and Programs										
9	Medical Director			18,008	18,008		18,008		18,008		9
10	Nursing and Medical Records	1,599,868	173,974	440,906	2,214,748		2,214,748		2,214,748		10
10a	Therapy	60,099	6,871	607,376	674,346		674,346	34,473	708,819		10a
11	Activities	47,825	2,060	780	50,665		50,665		50,665		11
12	Social Services	43,576	310	2,540	46,426		46,426		46,426		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,751,368	183,215	1,069,610	3,004,193		3,004,193	34,473	3,038,666		16
	C. General Administration										
17	Administrative			804,880	804,880		804,880	(650,613)	154,267		17
18	Directors Fees										18
19	Professional Services			6,263	6,263		6,263	37,057	43,320		19
20	Dues, Fees, Subscriptions & Promotions			34,574	34,574		34,574	(10,479)	24,095		20
21	Clerical & General Office Expenses	149,204	38,709	26,671	214,584		214,584	155,959	370,543		21
22	Employee Benefits & Payroll Taxes			255,488	255,488		255,488	31,101	286,589		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,118	1,118		1,118	(384)	734		24
25	Other Admin. Staff Transportation			7,110	7,110		7,110	27,325	34,435		25
26	Insurance-Prop.Liab.Malpractice			36,552	36,552		36,552	6,513	43,065		26
27	Other (specify):*										27
28	TOTAL General Administration	149,204	38,709	1,172,656	1,360,569		1,360,569	(403,521)	957,048		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,263,568	431,976	2,433,482	5,129,026		5,129,026	(358,024)	4,771,002		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Rosewood Care Center Rockford

#0041756

Report Period Beginning:

7/1/2001

Ending:

6/30/2002

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					2,129	2,129	229,690	231,819			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			53,587	53,587		53,587	392,068	445,655			32
33	Real Estate Taxes			92,078	92,078		92,078		92,078			33
34	Rent-Facility & Grounds			847,065	847,065		847,065	(833,838)	13,227			34
35	Rent-Equipment & Vehicles			31,827	31,827		31,827		31,827			35
36	Other (specify):*			2,129	2,129	(2,129)						36
37	TOTAL Ownership			1,026,686	1,026,686		1,026,686	(212,080)	814,606			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		301,228	20,799	322,027		322,027	(2,603)	319,424			39
40	Barber and Beauty Shops			4,138	4,138		4,138		4,138			40
41	Coffee and Gift Shops			65,700	65,700		65,700		65,700			41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		301,228	90,637	391,865		391,865	(2,603)	389,262			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,263,568	733,204	3,550,805	6,547,577		6,547,577	(572,707)	5,974,870			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Rockford

0041756

Report Period Beginning: 7/1/2001

Ending: 6/30/2002

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	(6,741)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,204)	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	(8,323)	32		10
11	Discounts, Allowances, Rebates & Refunds	(2,603)	39		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(268)	2		13
14	Non-Care Related Interest	(53,587)	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	(384)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(3,346)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(4,739)	20		28
29	Other-Attach Schedule Marketing Salary	(56,477)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (149,672)		\$	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)	(423,035)	Var	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (423,035)		36
37	TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)	\$ (572,707)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Care Center Rockford

ID# 0041756

Report Period Beginning: 7/1/2001

Ending: 6/30/2002

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Marketing Salary	\$ (56,477)	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
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30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(56,477)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Center Rockford

0041756 Report Period Beginning:

7/1/2001

Ending: 6/30/2002

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	(7,009)	0	0	0	0	0	0	0	0	0	0	(7,009)	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	420	0	0	0	0	0	0	0	0	420	5
6	Maintenance	0	0	17,613	0	0	0	0	0	0	0	0	17,613	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(7,009)	0	18,033	0	11,024	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	34,473	0	0	0	0	0	0	0	0	0	34,473	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	34,473	0	0	0	0	0	0	0	0	0	34,473	16
	C. General Administration													
17	Administrative	0	(804,880)	154,267	0	0	0	0	0	0	0	0	(650,613)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	37,057	0	0	0	0	0	0	0	0	37,057	19
20	Fees, Subscriptions & Promotions	(11,085)	0	606	0	0	0	0	0	0	0	0	(10,479)	20
21	Clerical & General Office Expenses	(66,681)	0	222,640	0	0	0	0	0	0	0	0	155,959	21
22	Employee Benefits & Payroll Taxes	0	0	31,101	0	0	0	0	0	0	0	0	31,101	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(384)	0	0	0	0	0	0	0	0	0	0	(384)	24
25	Other Admin. Staff Transportation	0	0	27,325	0	0	0	0	0	0	0	0	27,325	25
26	Insurance-Prop.Liab.Malpractice	0	0	6,513	0	0	0	0	0	0	0	0	6,513	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(78,150)	(804,880)	479,509	0	(403,521)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(85,159)	(770,407)	497,542	0	(358,024)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number **Rosewood Care Center Rockford**# **0041756** Report Period Beginning:

7/1/2001 Ending:

6/30/2002

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	206,321	23,369	0	0	0	0	0	0	0	0	229,690 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(61,910)	453,978	0	0	0	0	0	0	0	0	0	392,068 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	(847,065)	13,227	0	0	0	0	0	0	0	0	(833,838) 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	(61,910)	(186,766)	36,596	0	(212,080) 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	(2,603)	0	0	0	0	0	0	0	0	0	0	(2,603) 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	(2,603)	0	0	0	0	0	0	0	0	0	0	(2,603) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(149,672)	(957,173)	534,138	0	(572,707) 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	75.00%	See Attached List		See Attached List		
Darrell Hoefling	25.00%	See Attached List		See Attached List		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	17 Management Fee	\$ 804,880	HSM Management Services, Inc.	100.00%	\$	\$ (804,880)
2	V						
3	V	10a Therapy	607,376	Rosewood Therapy Services, Inc.	0.00%	641,849	34,473
4	V						
5	V	34 Rent	847,065	Rockford Real Estate, L.L.C.	0.00%		(847,065)
6	V	30 Depreciation		Rockford Real Estate, L.L.C.		206,321	206,321
7	V	32 Interest		Rockford Real Estate, L.L.C.		441,455	441,455
8	V	32 Amortization - Loan Fee		Rockford Real Estate, L.L.C.		12,523	12,523
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 2,259,321			\$ 1,302,148	\$ * (957,173)

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 See Schedule VIII	\$	HSM Management Services, Inc.	100.00%	\$ 154,267	\$ 154,267
16	V	21 See Schedule VIII		HSM Management Services, Inc.	100.00%	222,640	222,640
17	V	22 See Schedule VIII		HSM Management Services, Inc.	100.00%	31,101	31,101
18	V	25 See Schedule VIII		HSM Management Services, Inc.	100.00%	27,325	27,325
19	V	30 See Schedule VIII		HSM Management Services, Inc.	100.00%	23,369	23,369
20	V	34 See Schedule VIII		HSM Management Services, Inc.	100.00%	13,227	13,227
21	V	19 See Schedule VIII		HSM Management Services, Inc.	100.00%	37,057	37,057
22	V	26 See Schedule VIII		HSM Management Services, Inc.	100.00%	6,513	6,513
23	V	6 See Schedule VIII		HSM Management Services, Inc.	100.00%	17,613	17,613
24	V	5 See Schedule VIII		HSM Management Services, Inc.	100.00%	420	420
25	V	20 See Schedule VIII		HSM Management Services, Inc.	100.00%	606	606
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 534,138	\$ * 534,138

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

Facility Name & ID Number Rosewood Care Center Rockford # 0041756 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

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	Larry Vander Maten	President	Management	75.00%	820,978	3	6.34%	Salary	\$ 55,601	17-8	1
2	Darrell Hoefling	Vice-President	Management	25.00%	585,120	3	6.34%	Salary	39,628	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	\$ 95,229		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Rockford # 0041756 Report Period Beginning: 7/1/2001 Ending: 3/30/2002

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 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/(col.4)x col.6)	
1	17	Salaries - Officers	Total Cost	78,691,907	17	\$ 1,501,328	\$ 4,991,441	\$ 95,229	1
2	21	Salaries - Others	Total Cost	78,691,907	17	2,971,209	4,991,441	188,464	2
3	22	Payroll Taxes	Total Cost	78,691,907	17	275,345	4,991,441	17,465	3
4	22	Employee Benefits	Total Cost	78,691,907	17	147,178	4,991,441	9,336	4
5	25	Travel	Total Cost	78,691,907	17	280,565	4,991,441	17,796	5
6	30	Depreciation	Total Cost	78,691,907	17	359,545	4,991,441	22,806	6
7	34	Building Rent	Total Cost	78,691,907	17	208,527	4,991,441	13,227	7
8	19	Professional Services	Total Cost	78,691,907	17	584,225	4,991,441	37,057	8
9	21	Telephone	Total Cost	78,691,907	17	234,306	4,991,441	14,862	9
10	26	Insurance	Total Cost	78,691,907	17	102,679	4,991,441	6,513	10
11	21	Taxes, Licenses & Other Sup.	Total Cost	78,691,907	17	304,491	4,991,441	19,314	11
12	6	Maintenance	Total Cost	78,691,907	17	276,408	4,991,441	17,533	12
13	5	Heat & Other Utilities	Total Cost	78,691,907	17	6,619	4,991,441	420	13
14	20	Dues & Subscriptions	Total Cost	78,691,907	17	9,548	4,991,441	606	14
15	17	Direct - Admin	Direct Cost	1	1	59,038	1	59,038	15
16	17	Direct - Admin	Direct Cost	16	16	929,681	0	0	16
17	22	Direct - Payroll Taxes	Direct Cost	1	1	4,300	1	4,300	17
18	22	Direct - Payroll Taxes	Direct Cost	16	16	74,716	0	0	18
19	30	Direct - Depreciation	Direct Cost	1	1	563	1	563	19
20	30	Direct - Depreciation	Direct Cost	16	16	15,746	0	0	20
21	25	Direct - Travel	Direct Cost	1	1	9,529	1	9,529	21
22	25	Direct - Travel	Direct Cost	16	16	6,298	0	0	22
23	6	Direct - Maintenance	Direct Cost	1	1	80	1	80	23
24	6	Direct - Maintenance	Direct Cost	16	16	3,146	0	0	24
25	TOTALS					\$ 8,365,070	\$ 5,461,256	\$ 534,138	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Rockford# 0041756

Report Period Beginning:

7/1/2001

Ending:

6/30/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	Name of Lender	2		3	4	5	6		7	8	9	10						
			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		Firstar		X	Construction Financing	Varies	12/21/94	\$ 5,523,000	\$			Prm + 1/4	\$ 284,314	1					
2		Commerce Bank		X	Refinance	Varies	4/12/02	11,000,000	11,000,000			5.03%	178,922	2					
3		Less: Related Party Interest Income Offset											(21,781)	3					
4		Amortization of Loan Costs											12,523	4					
5		Interest Income											(8,323)	5					
		Working Capital																	
6														6					
7														7					
8														8					
9		TOTAL Facility Related						\$ 16,523,000	\$ 11,000,000			\$	445,655	9					
		B. Non-Facility Related*																	
10														10					
11														11					
12														12					
13														13					
14		TOTAL Non-Facility Related						\$	\$			\$		14					
15		TOTALS (line 9+line14)						\$ 16,523,000	\$ 11,000,000			\$	445,655	15					

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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

Facility Name & ID Number **Rosewood Care Center Rockford**# **0041756** Report Period Beginning: **7/1/2001** Ending: **6/30/2002****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1.	Real Estate Tax accrual used on 2001 report.			\$	102,000	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.)			\$	102,739	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	739	3
4.	Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	91,339	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.			\$	92,078	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		1997	116,241	8	FOR OHF USE ONLY	
		1998	107,881	9		
		1999	107,053	10	13	FROM R. E. TAX STATEMENT FOR 2001 \$ 13
		2000	101,600	11	14	PLUS APPEAL COST FROM LINE 5 \$ 14
		2001	103,877	12	15	LESS REFUND FROM LINE 6 \$ 15
	2000 Payment - \$50,800				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
	2001 Payment - \$51,939					
	Accrual = Remaining 2001 payment (51,939) + 1/2 of estimated 2002 tax bill (39,400)					

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 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, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rosewood Care Center Rockford COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0041756

CONTACT PERSON REGARDING THIS REPORT Chuck Schmitz

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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>12-34-102-022</u>	<u>Rosewood Sub Pt NW1/4</u>	\$ <u>99,050.90</u>	\$ <u>99,050.90</u>
2. _____	<u>34-44-2 Lot 1</u>	\$ _____	\$ _____
3. <u>12-34-101-028</u>	<u>Rosewood Sub Pt NW1/4</u>	\$ <u>4,826.52</u>	\$ <u>4,826.52</u>
4. _____	<u>34-44-2 Lot 2</u>	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>103,877.42</u>	\$ <u>103,877.42</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the 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.

Facility Name & ID Number Rosewood Care Center Rockford# 0041756 Report Period Beginning:7/1/2001 Ending:6/30/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 41,042 B. General Construction Type: Exterior Stucco Frame Wood Number of Stories 1C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

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

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

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

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>	<u>41,042</u>	<u>1994</u>	<u>\$ 262,474</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	41,042		\$ 262,474	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Rockford

0041756

Report Period Beginning:

7/1/2001

Ending:

6/30/2002

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 OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	120		1996	\$ 3,692,092	\$	40	\$ 92,302	\$ 92,302	\$ 569,196	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Left Turn Lane Street		1996	50,239		25	2,010	2,010	12,395	9
10	Parking Lot Paving		1996	95,573		25	3,823	3,823	23,575	10
11	Site Excavation		1996	83,290		25	3,332	3,332	20,547	11
12	Storm & Sanitary Sewers, and Site Water Line		1996	154,171		25	6,167	6,167	38,030	12
13	Sprinkler System		1996	24,160		25	966	966	5,957	13
14	Landscaping		1996	55,477		25	2,219	2,219	13,684	14
15	Architect Fees		1996	35,224		25	1,409	1,409	8,689	15
16	Site Work		1996	9,428		25	377	377	2,325	16
17	Contractor Fee		1996	21,047		25	842	842	5,192	17
18	Title Fee		1996	1,068		25	43	43	265	18
19	Builder's Risk		1996	2,159		25	86	86	530	19
20	Legal Fees		1996	1,851		25	74	74	456	20
21	Construction Interest		1996	29,594		25	1,184	1,184	7,301	21
22	Outdoor Signs, Monument Sign and Facility Signage		1996	14,259		10	1,426	1,426	8,794	22
23	Water Heater/Boiler/Hot Water Booster		1996	16,147		10	1,615	1,615	9,959	23
24	Emergency Generator		1996	29,359		10	2,936	2,936	18,105	24
25	Walk-in Cooler		1996	5,094		10	509	509	3,139	25
26	Alarm Annunciator, Fire Alarm System, Door Alarm		1996	29,030		10	2,903	2,903	17,902	26
27	Wallcovering & Painting		1996	67,810		10	6,781	6,781	41,816	27
28	Kitchen Exhaust Hoods		1996	6,883		10	688	688	4,243	28
29	Sinks/Drains		1996	6,712		10	671	671	4,138	29
30	Nurse Call System		1996	28,100		10	2,810	2,810	17,328	30
31	TV Cable & Antenna, Telephone & Paging Wiring		1996	70,140		10	7,014	7,014	43,253	31
32	Carpet		1996	8,915		10	892	892	5,501	32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Rockford

0041756

Report Period Beginning:

7/1/2001

Ending:

6/30/2002

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Leasehold Improvements - Management Company:							486	37
38	Office Construction/Improvements	1995	486		5			44	38
39	Office Design	1995	44		5			104	39
40	Office Shelving	1996	104		4			458	40
41	Office Expansion	1996	458		4			1,227	41
42	Office Expansion	1997	1,227		3			692	42
43	Office Expansion	1998	692		3	51	51	342	43
44	Office Addition	1999	342		3	114	114	147	44
45	Door Locks	1999	171		3	57	57		45
46									46
47									47
48									48
49									49
50	Leasehold Improvements - Facility:								50
51	Computer Cabling	2000	2,392	342	7	342		542	51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,543,738	\$ 342		\$ 143,643	\$ 143,301	\$ 886,362	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	\$ 717,209	\$ 1,330	\$ 78,492	\$ 77,162	5-7 Yrs	\$ 412,276	71
72	Current Year Purchases	23,609	457	2,035	1,578	5-7 Yrs	2,035	72
73	Fully Depreciated Assets	33,955					33,955	73
74								74
75	TOTALS	\$ 774,773	\$ 1,787	\$ 80,527	\$ 78,740		\$ 448,266	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	HSM Management	Various	Various	\$ 31,193	\$	\$ 7,649	\$ 7,649	5 Yrs	\$ 20,933	76
77										77
78										78
79										79
80	TOTALS			\$ 31,193	\$	\$ 7,649	\$ 7,649		\$ 20,933	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,612,178	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 2,129	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 231,819	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 229,690	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,355,561	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?
 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: \$ _____ 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 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>SCHEDULE NOT APPLICABLE - ONLY HIRE CERTIFIED AIDES 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 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			
		1	2	3	4
		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)	\$			

- (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.

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	

- (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.
- SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost	Units	Cost				
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	10a-8	hrs	\$	22,273	\$	292,873	\$			22,273	\$	292,873	1
2	Licensed Speech and Language Development Therapist	10a-8	hrs		3,685		67,748				3,685		67,748	2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist	10a-8	hrs		28,031		281,228		6,871		28,031		288,099	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						285,353				285,353	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Exceptional Care Program													12
13	Laboratory, X-Ray, Enterals Other (specify): & Ambulance	39-8							34,071				34,071	13
14	TOTAL			\$	53,989	\$	641,849	\$	326,295		53,989	\$	968,144	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.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Rosewood Care Center Rockford

0041756

Report Period Beginning: 7/1/2001

Ending:

6/30/2002

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2002

(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	\$ 228,747	\$	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance 115,000)	1,476,524		3
4 Supply Inventory (priced at)			4
5 Short-Term Investments			5
6 Prepaid Insurance			6
7 Other Prepaid Expenses			7
8 Accounts Receivable (owners or related parties)			8
9 Other(specify):	3,409		9
10 TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,708,680	\$	10
B. Long-Term Assets			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land			13
14 Buildings, at Historical Cost	20,732		14
15 Leasehold Improvements, at Historical Cost	(3,659)		15
16 Equipment, at Historical Cost			16
17 Accumulated Depreciation (book methods)			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)	\$ 17,073	\$	24
25 TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,725,753	\$	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 547,414	\$	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits			28
29 Short-Term Notes Payable	670,406		29
30 Accrued Salaries Payable	167,489		30
31 Accrued Taxes Payable (excluding real estate taxes)	44,708		31
32 Accrued Real Estate Taxes(Sch.IX-B)	91,339		32
33 Accrued Interest Payable	22,701		33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
Other Current Liabilities(specify):			
36 Accrued Management Fees	287,656		36
37 Accrued Rent	73,700		37
38 TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,905,413	\$	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)	\$ 1,905,413	\$	46
47 TOTAL EQUITY(page 18, line 24)	\$ (179,660)	\$	47
48 TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,725,753	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (308,431)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (308,431)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	128,771	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)	\$ 128,771	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)	\$ (179,660)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 7,141,324	1
2	Discounts and Allowances for all Levels	(2,845,306)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,296,018	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,444,754	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,444,754	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	6,921	13
14	Non-Patient Meals	6,741	14
15	Telephone, Television and Radio	10,204	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)	\$ 23,866	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	8,323	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,323	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Lab Discounts	2,603	28
28a	Miscellaneous	300	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,903	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,775,864	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	764,264	31
32	Health Care	3,004,193	32
33	General Administration	1,360,569	33
B. Capital Expense			
34	Ownership	1,026,686	34
C. Ancillary Expense			
35	Special Cost Centers	326,165	35
36	Provider Participation Fee	65,700	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,547,577	40
41	Income before Income Taxes (line 30 minus line 40)**	228,287	41
42	Income Taxes	(99,516)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 128,771	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

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

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

Facility Name & ID Number **Rosewood Care Center Rockford**

0041756

Report Period Beginning: **7/1/2001**

Ending:

6/30/2002

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	1,720	1,786	\$ 42,803	\$ 23.97	1
2	Assistant Director of Nursing	1,529	1,587	34,928	22.01	2
3	Registered Nurses	15,936	16,545	323,681	19.56	3
4	Licensed Practical Nurses	24,381	25,313	433,625	17.13	4
5	Nurse Aides & Orderlies	68,576	71,197	701,473	9.85	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,228	4,390	60,099	13.69	8
9	Activity Director					9
10	Activity Assistants	5,989	6,218	47,825	7.69	10
11	Social Service Workers	4,131	4,288	43,576	10.16	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,879	22,715	183,242	8.07	15
16	Dishwashers					16
17	Maintenance Workers	2,598	2,698	26,648	9.88	17
18	Housekeepers	16,260	16,882	118,628	7.03	18
19	Laundry	4,922	5,110	34,478	6.75	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,091	14,630	149,204	10.20	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,946	5,134	63,358	12.34	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	191,186	198,493	\$ 2,263,568 *	\$ 11.40	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	495	\$ 11,347	1-3	35
36	Medical Director	Contract	18,008	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	30	780	11-3	44
45	Social Service Consultant	30	2,540	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	555	\$ 32,675		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,906	\$ 81,708	10-3	50
51	Licensed Practical Nurses	8,539	267,810	10-3	51
52	Nurse Aides	4,344	91,388	10-3	52
53	TOTAL (lines 50 - 52)	14,789	\$ 440,906		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

Facility Name & ID Number Rosewood Care Center Rockford

STATE OF ILLINOIS

0041756

Report Period Beginning: 7/1/2001

Page 23

Ending: 6/30/2002

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Association
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 48,713 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 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 of Public Aid during this cost report period. \$ 65,700
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department 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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 6,741
- (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? Yes
Firm Name: C.J. Schlosser & Company The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit not finished
- (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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

ROSEWOOD CARE CENTER OF ROCKFORD
 IDPH ID #0041756
 ATTACHMENT TO SCHEDULE V, LINE 25
 6/30/2002

OTHER ADMIN. STAFF TRANSPORTATION:

MILEAGE REIMBURSEMENT **	\$7,110
	<u>7,110</u>

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

ROSEWOOD CARE CENTER OF ROCKFORD
 IDPH ID #0041756
 ATTACHMENT TO SCHEDULE VII, SECTION A.
 6/30/2002

RELATED NURSING HOME:

ROSEWOOD CARE CENTER OF ALTON
 ROSEWOOD CARE CENTER OF EAST PEORIA
 ROSEWOOD CARE CENTER OF EDWARDSVILLE
 ROSEWOOD CARE CENTER OF ELGIN
 ROSEWOOD CARE CENTER OF GALESBURG
 ROSEWOOD CARE CENTER OF INVERNESS
 ROSEWOOD CARE CENTER OF JOLIET
 ROSEWOOD CARE CENTER OF MOLINE
 ROSEWOOD CARE CENTER OF NORTHBROOK
 ROSEWOOD CARE CENTER OF PEORIA
 ROSEWOOD CARE CENTER OF ST. CHARLES
 ROSEWOOD CARE CENTER OF ST. LOUIS
 ROSEWOOD CARE CENTER OF SWANSEA

CITY:

ALTON, IL
 EAST PEORIA, IL
 EDWARDSVILLE, IL
 ELGIN, IL
 GALESBURG, IL
 INVERNESS, IL
 JOLIET, IL
 MOLINE, IL
 NORTHBROOK, IL
 PEORIA, IL
 ST. CHARLES, IL
 ST. LOUIS, MO
 SWANSEA, IL

OTHER RELATED BUSINESS ENTITIES:

HSM MANAGEMENT SERVICES, INC.
 ROCKFORD REAL ESTATE, INC.
 HSM DEVELOPMENT, INC.
 RCC HOLDING COMPANY
 ROSEWOOD HOME HEALTH
 ROSEWOOD THERAPY SERVICES

TYPE OF BUSINESS:

MANAGEMENT CO.
 REAL ESTATE LSG.
 DEVELOPMENT CO.
 HOLDING COMPANY
 HOME HEALTH CO.
 THERAPY COMPANY

ROSEWOOD CARE CENTER INC. OF ROCKFORD
 RECLASSIFICATIONS
 06/30/02

DESCRIPTION	SCHED V LINE #	INCREASE (DECREASE)
OTHER	36	(2,129)
DEPRECIATION TO RECLASS DEPRECIATION EXPENSE DUE TO PROTECTED CELL	30	2,129