

Facility Name & ID Number Rosewood Care Center of Elgin

0040006 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>139</u>	Skilled (SNF)	<u>139</u>	<u>50,735</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>139</u>	TOTALS	<u>139</u>	<u>50,735</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	4 Other		
8	SNF			<u>7,016</u>	<u>7,016</u>	8
9	SNF/PED					9
10	ICF	<u>12,558</u>	<u>19,447</u>		<u>32,005</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>12,558</u>	<u>19,447</u>	<u>7,016</u>	<u>39,021</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.91%

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

64 (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 11/4/94

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

YES Date 11/4/94 NO

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

YES NO If YES, enter number of beds certified 40 and days of care provided 7,016

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

Facility Name & ID Number Rosewood Care Center of Elgin # 0040006 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	195,428	27,382	8,075	230,885		230,885		230,885		1
2	Food Purchase		174,933		174,933		174,933	(2,515)	172,418		2
3	Housekeeping	162,704	30,231		192,935		192,935		192,935		3
4	Laundry	48,994	16,813		65,807		65,807		65,807		4
5	Heat and Other Utilities			138,783	138,783		138,783	494	139,277		5
6	Maintenance	26,792	6,853	83,869	117,514		117,514	20,976	138,490		6
7	Other (specify):* Sanitation			20,911	20,911		20,911		20,911		7
8	TOTAL General Services	433,918	256,212	251,638	941,768		941,768	18,955	960,723		8
	B. Health Care and Programs										
9	Medical Director			41,625	41,625		41,625		41,625		9
10	Nursing and Medical Records	2,636,172	212,477		2,848,649		2,848,649		2,848,649		10
10a	Therapy	99,327	1,721	330,368	431,416		431,416	131,879	563,295		10a
11	Activities	53,720	6,872	1,874	62,466		62,466		62,466		11
12	Social Services	64,527		2,144	66,671		66,671		66,671		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,853,746	221,070	376,011	3,450,827		3,450,827	131,879	3,582,706		16
	C. General Administration										
17	Administrative			463,028	463,028		463,028	(282,168)	180,860		17
18	Directors Fees										18
19	Professional Services			3,940	3,940		3,940	43,594	47,534		19
20	Dues, Fees, Subscriptions & Promotions			29,228	29,228		29,228	(10,134)	19,094		20
21	Clerical & General Office Expenses	158,332	40,916	17,212	216,460		216,460	186,950	403,410		21
22	Employee Benefits & Payroll Taxes			394,945	394,945		394,945	37,230	432,175		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,914	1,914		1,914		1,914		24
25	Other Admin. Staff Transportation			7,641	7,641		7,641	21,176	28,817		25
26	Insurance-Prop.Liab.Malpractice			41,990	41,990		41,990	7,662	49,652		26
27	Other (specify):*										27
28	TOTAL General Administration	158,332	40,916	959,898	1,159,146		1,159,146	4,310	1,163,456		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,445,996	518,198	1,587,547	5,551,741		5,551,741	155,144	5,706,885		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Rosewood Care Center of Elgin

#0040006

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					7,501	7,501	234,435	241,936			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			76,840	76,840		76,840	307,336	384,176			32
33	Real Estate Taxes			93,533	93,533		93,533		93,533			33
34	Rent-Facility & Grounds			1,260,368	1,260,368		1,260,368	(1,244,808)	15,560			34
35	Rent-Equipment & Vehicles			19,172	19,172		19,172		19,172			35
36	Other (specify):*			7,501	7,501	(7,501)						36
37	TOTAL Ownership			1,457,414	1,457,414		1,457,414	(703,037)	754,377			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		202,121	13,658	215,779		215,779	(1,352)	214,427			39
40	Barber and Beauty Shops			2,684	2,684		2,684		2,684			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			76,103	76,103		76,103		76,103			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		202,121	92,445	294,566		294,566	(1,352)	293,214			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,445,996	720,319	3,137,406	7,303,721		7,303,721	(549,245)	6,754,476			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Elgin

0040006

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	(2,083)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(10,171)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,352)	39		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(432)	2		13
14	Non-Care Related Interest	(76,840)	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				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	(4,330)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(3,516)	20		28
29	Other-Attach Schedule Marketing Salary	(74,964)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (176,688)		\$	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)			34
35	Other- Attach Schedule	(372,557)	Var	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (372,557)		36
37	TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)	\$ (549,245)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Care Center of Elgin

ID# 0040006

Report Period Beginning: 7/1/2001

Ending: 6/30/2002

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Marketing Salary	\$ (74,964)	21
2			
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49	Total	(74,964)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Center of Elgin

0040006 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	(2,515)	0	0	0	0	0	0	0	0	0	0	(2,515)	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	494	0	0	0	0	0	0	0	0	494	5
6	Maintenance	0	0	20,976	0	0	0	0	0	0	0	0	20,976	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,515)	0	21,470	0	18,955	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	131,879	0	0	0	0	0	0	0	0	0	131,879	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	131,879	0	0	0	0	0	0	0	0	0	131,879	16
	C. General Administration													
17	Administrative	0	(463,028)	180,860	0	0	0	0	0	0	0	0	(282,168)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	43,594	0	0	0	0	0	0	0	0	43,594	19
20	Fees, Subscriptions & Promotions	(10,846)	0	712	0	0	0	0	0	0	0	0	(10,134)	20
21	Clerical & General Office Expenses	(74,964)	0	261,914	0	0	0	0	0	0	0	0	186,950	21
22	Employee Benefits & Payroll Taxes	0	0	37,230	0	0	0	0	0	0	0	0	37,230	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	21,176	0	0	0	0	0	0	0	0	21,176	25
26	Insurance-Prop.Liab.Malpractice	0	0	7,662	0	0	0	0	0	0	0	0	7,662	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(85,810)	(463,028)	553,148	0	4,310	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(88,325)	(331,149)	574,618	0	155,144	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Center of Elgin# 0040006 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	207,043	27,392	0	0	0	0	0	0	0	0	234,435 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(87,011)	394,347	0	0	0	0	0	0	0	0	0	307,336 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	(1,260,368)	15,560	0	0	0	0	0	0	0	0	(1,244,808) 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	(87,011)	(658,978)	42,952	0	(703,037) 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	(1,352)	0	0	0	0	0	0	0	0	0	0	(1,352) 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	(1,352)	0	0	0	0	0	0	0	0	0	0	(1,352) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(176,688)	(990,127)	617,570	0	(549,245) 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	\$ 463,028	HSM Management Services, Inc.	100.00%	\$	\$ (463,028)	1
2	V							2
3	V	10a Therapy	330,368	Rosewood Therapy Services, Inc.	0.00%	462,247	131,879	3
4	V							4
5	V	34 Rent	1,260,368	Elgin Real Estate L.L.C.	0.00%		(1,260,368)	5
6	V	30 Depreciation		Elgin Real Estate L.L.C.		207,043	207,043	6
7	V	32 Interest		Elgin Real Estate L.L.C.		369,080	369,080	7
8	V	32 Amortization - Loan Fee		Elgin Real Estate L.L.C.		25,267	25,267	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 2,053,764			\$ 1,063,637	\$ * (990,127)	14

* 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%	\$ 180,860	\$ 180,860	15
16	V	21 See Schedule VIII		HSM Management Services, Inc.	100.00%	261,914	261,914	16
17	V	22 See Schedule VIII		HSM Management Services, Inc.	100.00%	37,230	37,230	17
18	V	25 See Schedule VIII		HSM Management Services, Inc.	100.00%	21,176	21,176	18
19	V	30 See Schedule VIII		HSM Management Services, Inc.	100.00%	27,392	27,392	19
20	V	34 See Schedule VIII		HSM Management Services, Inc.	100.00%	15,560	15,560	20
21	V	19 See Schedule VIII		HSM Management Services, Inc.	100.00%	43,594	43,594	21
22	V	26 See Schedule VIII		HSM Management Services, Inc.	100.00%	7,662	7,662	22
23	V	6 See Schedule VIII		HSM Management Services, Inc.	100.00%	20,976	20,976	23
24	V	5 See Schedule VIII		HSM Management Services, Inc.	100.00%	494	494	24
25	V	20 See Schedule VIII		HSM Management Services, Inc.	100.00%	712	712	25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 617,570	\$ * 617,570	39

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

Facility Name & ID Number Rosewood Care Center of Elgin # 0040006 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%	811,171	3	7.46%	Salary	\$ 65,410	17-8	1
2	Darrell Hoefling	Vice-President	Management	25.00%	578,130	3	7.46%	Salary	46,618	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	\$ 112,028		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Elgin # 0040006 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	\$ 5,871,911	\$ 112,028	1
2	21	Salaries - Others	Total Cost	78,691,907	17	2,971,209	5,871,911	221,709	2
3	22	Payroll Taxes	Total Cost	78,691,907	17	275,345	5,871,911	20,546	3
4	22	Employee Benefits	Total Cost	78,691,907	17	147,178	5,871,911	10,982	4
5	25	Travel	Total Cost	78,691,907	17	280,565	5,871,911	20,935	5
6	30	Depreciation	Total Cost	78,691,907	17	359,545	5,871,911	26,829	6
7	34	Building Rent	Total Cost	78,691,907	17	208,527	5,871,911	15,560	7
8	19	Professional Services	Total Cost	78,691,907	17	584,225	5,871,911	43,594	8
9	21	Telephone	Total Cost	78,691,907	17	234,306	5,871,911	17,484	9
10	26	Insurance	Total Cost	78,691,907	17	102,679	5,871,911	7,662	10
11	21	Taxes, Licenses & Other Sup.	Total Cost	78,691,907	17	304,491	5,871,911	22,721	11
12	6	Maintenance	Total Cost	78,691,907	17	276,408	5,871,911	20,625	12
13	5	Heat & Other Utilities	Total Cost	78,691,907	17	6,619	5,871,911	494	13
14	20	Dues & Subscriptions	Total Cost	78,691,907	17	9,548	5,871,911	712	14
15	17	Direct - Admin	Direct Cost	1	1	68,832	68,832	1	68,832
16	17	Direct - Admin	Direct Cost	16	16	919,887	919,887	0	0
17	22	Direct - Payroll Taxes	Direct Cost	1	1	5,702		1	5,702
18	22	Direct - Payroll Taxes	Direct Cost	16	16	73,314		0	0
19	30	Direct - Depreciation	Direct Cost	1	1	563		1	563
20	30	Direct - Depreciation	Direct Cost	16	16	15,746		0	0
21	25	Direct - Travel	Direct Cost	1	1	241		1	241
22	25	Direct - Travel	Direct Cost	16	16	15,586		0	0
23	6	Maintenance	Direct Cost	1	1	351		1	351
24	6	Maintenance	Direct Cost	16	16	2,875		0	0
25	TOTALS					\$ 8,365,070	\$ 5,461,256	\$ 617,570	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Elgin # 0040006 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	Purpose of Loan	4	Monthly Payment Required	5	Date of Note	6		7	8	Maturity Date	9	Interest Rate (4 Digits)	10	Reporting Period Interest Expense
			Related**								Original	Balance							
			YES	NO															
		A. Directly Facility Related																	
		Long-Term																	
1		Bank of America		X	Mortgage Refinanced			3/1999	\$ 10,500,000	\$ 9,144,008	3/2006	Prm + 1/2	\$ 388,001	1					
2		Less: Related Party Interest Income Offset											(18,921)	2					
3		Amortization of Loan Fees											25,267	3					
4		Interest Income											(10,171)	4					
5														5					
		Working Capital																	
6														6					
7														7					
8														8					
9		TOTAL Facility Related						\$ 10,500,000	\$ 9,144,008				\$ 384,176	9					
		B. Non-Facility Related*																	
10														10					
11														11					
12														12					
13														13					
14		TOTAL Non-Facility Related						\$	\$				\$	14					
15		TOTALS (line 9+line14)						\$ 10,500,000	\$ 9,144,008				\$ 384,176	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 of Elgin**# **0040006** 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.			\$	90,225	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.)			\$	90,712	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	487	3
4.	Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	93,046	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.			\$	93,533	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		1997	81,132	8	FOR OHF USE ONLY	
		1998	82,519	9	13	FROM R. E. TAX STATEMENT FOR 2001 \$ 13
		1999	87,214	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
		2000	89,332	11	15	LESS REFUND FROM LINE 6 \$ 15
		2001	92,092	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
2000 Payment - \$44,666						
2001 Payment - \$46,046						
Accrual = 2001 remaining (46,046) + 1/2 of estimated 2002 tax bill (47,000)						

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 of Elgin COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0040006

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>06-09-100-021</u>	<u>2355 Royal</u>	\$ <u>92,091.86</u>	\$ <u>92,091.86</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>92,091.86</u>	\$ <u>92,091.86</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 of Elgin# 0040006 Report Period Beginning:7/1/2001 Ending:6/30/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,268 B. General Construction Type: Exterior Brick 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>206,817</u>	<u>1993</u>	<u>\$ 590,758</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	<u>206,817</u>		<u>\$ 590,758</u>	<u>3</u>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Elgin# 0040006

Report Period Beginning:

7/1/2001

Ending:

6/30/2002**XL 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	139		1994	\$ 4,829,673	\$	25-40	\$ 128,067	\$ 128,067	\$ 981,846	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Landscaping		1996	4,792		25	192	192	1,248	9
10	Hot Water Booster		1994	661		10	66	66	506	10
11	Building Sign		1994	1,827		10	183	183	1,403	11
12	Walk-in Cooler		1994	5,231		10	523	523	4,010	12
13	Salad Prep Sink		1994	1,966		10	197	197	1,510	13
14	Exhaust Hood		1994	7,104		10	710	710	5,443	14
15	Worktable with Sink		1994	1,003		10	100	100	767	15
16	Pot & Pan Sink		1994	3,053		10	305	305	2,338	16
17	Signage		1994	5,796		10	579	579	4,439	17
18	Addition to Phone System		1994	3,218		10	321	321	2,461	18
19	Interior Signs		1994	7,506		10	751	751	5,758	19
20	Windowsills/Panels		1994	818		10	82	82	629	20
21	Water Heaters		1994	3,162		10	316	316	2,423	21
22	Water Heater		1994	1,283		10	128	128	981	22
23	Emergency Generator		1994	27,491		10	2,749	2,749	21,076	23
24	Carpet		1994	7,303		10	730	730	5,597	24
25	Wallpaper/Painting		1994	76,500		10	7,650	7,650	58,650	25
26	Telephone		1994	7,550		10	755	755	5,788	26
27										27
28	Leasehold Improvements - Facility:									
29	Painting		1998	16,105	2,300	7	2,300		9,078	29
30	Door Repairs		1998	4,778	683	7	683		2,561	30
31	Mini Blinds/Wallcovering/Wallpaper		1999	6,187	884	7	884		2,752	31
32	Carpeting		1999	10,413	1,487	7	1,487		4,369	32
33	Drapes		2000	10,234	1,462	7	1,462		3,290	33
34	Computer Cabling		2000	2,392	342	7	342		542	34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Elgin

0040006

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:		\$	\$		\$	\$	\$		37
38	Office Construction/Improvements	1995	571		5			571		38
39	Office Design	1995	52		5			52		39
40	Office Shelving	1996	122		4			122		40
41	Office Expansion	1996	539		4			539		41
42	Office Expansion	1997	1,444		3			1,444		42
43	Office Expansion	1998	815		3	60	60	815		43
44	Office Addition	1999	402		3	134	134	402		44
45	Door Locks	1999	201		3	67	67	173		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)		\$ 5,050,192	\$ 7,158		\$ 151,823	\$ 144,665	\$ 1,133,583		70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	\$ 718,560	\$ 343	\$ 79,398	\$ 79,055	5-7 Yrs	\$ 518,000	71
72	Current Year Purchases	14,751		1,717	1,717	5-7 Yrs	1,717	72
73	Fully Depreciated Assets	39,064					39,064	73
74								74
75	TOTALS	\$ 772,375	\$ 343	\$ 81,115	\$ 80,772		\$ 558,781	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	\$ 36,695	\$	\$ 8,998	\$ 8,998	4 Yrs	\$ 24,626	76
77										77
78										78
79										79
80	TOTALS			\$ 36,695	\$	\$ 8,998	\$ 8,998		\$ 24,626	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)	\$ 6,450,020	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 7,501	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 241,936	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 234,435	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,716,990	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section Not Applicable	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Section Not Applicable	\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Schedule Not Applicable
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO
 If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 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>N//A - 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 of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	10a-8	hrs	\$	12,314	\$	226,135	\$			12,314	\$	226,135	1
2	Licensed Speech and Language Development Therapist	10a-8	hrs		3,297		56,362				3,297		56,362	2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist	10a-8	hrs		13,755		179,750		1,721		13,755		181,471	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						160,460				160,460	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Exceptional Care Program													12
13	Laboratory, Ambulance, X-Ray Other (specify): & Enterals	39-8							53,967				53,967	13
14	TOTAL			\$	29,366	\$	462,247	\$	216,148		29,366	\$	678,395	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 of Elgin

0040006

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	\$ 539,482	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,405,149		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):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,944,631	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	52,506		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(23,278)		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)	\$ 29,228	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,973,859	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 441,110	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	788,105		29
30	Accrued Salaries Payable	320,717		30
31	Accrued Taxes Payable (excluding real estate taxes)	54,942		31
32	Accrued Real Estate Taxes(Sch.IX-B)	93,046		32
33	Accrued Interest Payable	38,104		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Management Fees	197,054		36
37	Accrued rent	(41,893)		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,891,185	\$	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)	\$ 1,891,185	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 82,674	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,973,859	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 72,546	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 72,546	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	\$ 38,128	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	\$ (28,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 10,128	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)	\$ 82,674	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Elgin

0040006

Report Period Beginning: 7/1/2001

Ending: 6/30/2002

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	\$ 7,548,377	1
2	Discounts and Allowances for all Levels	(1,507,817)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,040,560	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,347,714	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,347,714	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	5,567	13
14	Non-Patient Meals	2,083	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)	\$ 7,650	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	10,171	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10,171	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Lab Discounts	1,352	28
28a	Miscellaneous	2,984	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,336	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,410,431	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	941,768	31
32	Health Care	3,450,827	32
33	General Administration	1,159,146	33
B. Capital Expense			
34	Ownership	1,457,414	34
C. Ancillary Expense			
35	Special Cost Centers	218,463	35
36	Provider Participation Fee	76,103	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,303,721	40
41	Income before Income Taxes (line 30 minus line 40)**	106,710	41
42	Income Taxes	(68,582)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 38,128	43

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

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

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

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

Facility Name & ID Number **Rosewood Care Center of Elgin**

0040006

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	2,056	2,153	\$ 70,658	\$ 32.82	1
2	Assistant Director of Nursing	2,069	2,167	55,471	25.60	2
3	Registered Nurses	39,584	41,457	1,007,624	24.31	3
4	Licensed Practical Nurses	9,785	10,248	209,018	20.40	4
5	Nurse Aides & Orderlies	91,822	96,167	1,219,772	12.68	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,179	5,424	99,327	18.31	8
9	Activity Director					9
10	Activity Assistants	5,425	5,682	53,720	9.45	10
11	Social Service Workers	4,644	4,863	64,527	13.27	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,509	21,479	195,428	9.10	15
16	Dishwashers					16
17	Maintenance Workers	2,377	2,489	26,792	10.76	17
18	Housekeepers	16,329	17,101	162,704	9.51	18
19	Laundry	5,803	6,077	48,994	8.06	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,356	11,894	158,332	13.31	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	4,334	4,539	73,629	16.22	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	221,272	231,740	\$ 3,445,996 *	\$ 14.87	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	325	\$ 8,075	1-3	35
36	Medical Director	Contract	41,625	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	105	1,874	11-3	44
45	Social Service Consultant	105	2,144	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	535	\$ 53,718		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ Section Not Applicable	50
51	Licensed Practical Nurses			51
52	Nurse Aides			52
53	TOTAL (lines 50 - 52)		\$	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									
1	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	Schedule Not Applicable		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Elgin# 0040006Report Period Beginning: 7/1/2001Ending: 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. \$ 84,628 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. \$ 76,103
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. \$ 2,083
- (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 INC. OF ELGIN
 RECLASSIFICATIONS
 06/30/02

DESCRIPTION	SCHED V LINE #	INCREASE (DECREASE)
OTHER	36	(7,501)
DEPRECIATION TO RECLASS DEPRECIATION EXPENSE DUE TO PROTECTED CELL	30	7,501

ROSEWOOD CARE CENTER OF ELGIN
 IDPH ID #0040006
 ATTACHMENT TO SCHEDULE V, LINE 25
 6/30/2002

OTHER ADMIN. STAFF TRANSPORTATION:

MILEAGE REIMBURSEMENT **	\$7,641
	<u>7,641</u>

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

ROSEWOOD CARE CENTER OF ELGIN
 IDPH ID #0040006
 ATTACHMENT TO SCHEDULE VII, SECTION A.
 6/30/2002

RELATED NURSING HOME:

CITY:

ROSEWOOD CARE CENTER OF ALTON	ALTON, IL
ROSEWOOD CARE CENTER OF EAST PEORIA	EAST PEORIA, IL
ROSEWOOD CARE CENTER OF EDWARDSVILLE	EDWARDSVILLE, IL
ROSEWOOD CARE CENTER OF GALESBURG	GALESBURG, IL
ROSEWOOD CARE CENTER OF INVERNESS	INVERNESS, IL
ROSEWOOD CARE CENTER OF JOLIET	JOLIET, IL
ROSEWOOD CARE CENTER OF MOLINE	MOLINE, IL
ROSEWOOD CARE CENTER OF NORTHBROOK	NORTHBROOK, IL
ROSEWOOD CARE CENTER OF PEORIA	PEORIA, IL
ROSEWOOD CARE CENTER OF ROCKFORD	ROCKFORD, IL
ROSEWOOD CARE CENTER OF ST. CHARLES	ST. CHARLES, IL
ROSEWOOD CARE CENTER OF ST. LOUIS	ST. LOUIS, MO
ROSEWOOD CARE CENTER OF SWANSEA	SWANSEA, IL

OTHER RELATED BUSINESS ENTITIES:

TYPE OF BUSINESS:

HSM MANAGEMENT SERVICES, INC.	MANAGEMENT CO.
ELGIN REAL ESTATE, LLC	REAL ESTATE LSG.
HSM DEVELOPMENT, INC.	DEVELOPMENT CO.
RCC HOLDING COMPANY	HOLDING COMPANY
ROSEWOOD HOME HEALTH	HOME HEALTH CO.
ROSEWOOD THERAPY SERVICES	THERAPY COMPANY