

Facility Name & ID Number Rosewood Care Center Rockford

0041756 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

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>10,149</u>	<u>10,149</u>	8
9	SNF/PED					9
10	ICF	<u>8,672</u>	<u>12,080</u>		<u>20,752</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>8,672</u>	<u>12,080</u>	<u>10,149</u>	<u>30,901</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.55%

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

135 (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 5/20/1996

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

YES Date 5/20/1996 NO

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

YES NO If YES, enter number of beds certified 70 and days of care provided 10,149

Medicare Intermediary Tri-Span

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/2003 Fiscal Year: 6/30/2003

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

STATE OF ILLINOIS

Facility Name & ID Number Rosewood Care Center Rockford # 0041756 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
A. General Services											
1	Dietary	184,691	15,860	8,798	209,349		209,349		209,349		1
2	Food Purchase		126,097		126,097		126,097	(4,720)	121,377		2
3	Housekeeping	124,311	23,517		147,828		147,828		147,828		3
4	Laundry	36,111	12,991		49,102		49,102		49,102		4
5	Heat and Other Utilities			103,976	103,976		103,976	203	104,179		5
6	Maintenance	28,314	15,184	74,512	118,010		118,010	18,941	136,951		6
7	Other (specify):* Sanitation			7,093	7,093		7,093		7,093		7
8	TOTAL General Services	373,427	193,649	194,379	761,455		761,455	14,424	775,879		8
B. Health Care and Programs											
9	Medical Director			13,003	13,003		13,003		13,003		9
10	Nursing and Medical Records	1,589,889	159,315	551,111	2,300,315		2,300,315		2,300,315		10
10a	Therapy	63,074	1,471	422,314	486,859		486,859	55,134	541,993		10a
11	Activities	45,120	2,737	2,000	49,857		49,857		49,857		11
12	Social Services	41,793	390	2,200	44,383		44,383		44,383		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,739,876	163,913	990,628	2,894,417		2,894,417	55,134	2,949,551		16
C. General Administration											
17	Administrative			132,000	132,000		132,000	(7,602)	124,398		17
18	Directors Fees										18
19	Professional Services			3,790	3,790		3,790	41,380	45,170		19
20	Dues, Fees, Subscriptions & Promotions			24,871	24,871		24,871	(8,499)	16,372		20
21	Clerical & General Office Expenses	159,746	34,522	27,361	221,629		221,629	166,138	387,767		21
22	Employee Benefits & Payroll Taxes			278,788	278,788		278,788	27,949	306,737		22
23	Inservice Training & Education										23
24	Travel and Seminar			977	977		977		977		24
25	Other Admin. Staff Transportation			5,574	5,574		5,574	13,948	19,522		25
26	Insurance-Prop.Liab.Malpractice			48,178	48,178		48,178	9,837	58,015		26
27	Other (specify):*										27
28	TOTAL General Administration	159,746	34,522	521,539	715,807		715,807	243,151	958,958		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,273,049	392,084	1,706,546	4,371,679		4,371,679	312,709	4,684,388		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:

7/1/2002

Ending:

6/30/2003

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			3,597	3,597		3,597	229,625	233,222			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			35,737	35,737		35,737	464,063	499,800			32
33	Real Estate Taxes			122,864	122,864		122,864		122,864			33
34	Rent-Facility & Grounds			784,200	784,200		784,200	(772,690)	11,510			34
35	Rent-Equipment & Vehicles			13,326	13,326		13,326		13,326			35
36	Other (specify):*											36
37	TOTAL Ownership			959,724	959,724		959,724	(79,002)	880,722			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		212,567	23,948	236,515		236,515	(2,097)	234,418			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		212,567	89,648	302,215		302,215	(2,097)	300,118			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,273,049	604,651	2,755,918	5,633,618		5,633,618	231,610	5,865,228			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: 7/1/2002

Ending: 6/30/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,476)	2		4
5	Telephone, TV & Radio in Resident Rooms	(13,771)	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	(3,991)	32		10
11	Discounts, Allowances, Rebates & Refunds	(2,097)	39		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(244)	2		13
14	Non-Care Related Interest	(35,737)	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	(1,877)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(4,415)	20		28
29	Other-Attach Schedule Marketing Salary	(57,867)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (127,475)		\$	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)	359,085	Var	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 359,085		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 231,610		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: 7/1/2002

Ending: 6/30/2003

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$ (57,867)	21
2			
3			
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49	Total	(57,867)	

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Center Rockford

0041756 Report Period Beginning:

7/1/2002

Ending: 6/30/2003

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	(4,720)	0	0	0	0	0	0	0	0	0	0	(4,720)	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	203	0	0	0	0	0	0	0	0	203	5
6	Maintenance	0	0	18,941	0	0	0	0	0	0	0	0	18,941	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(4,720)	0	19,144	0	14,424	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	55,134	0	0	0	0	0	0	0	0	0	55,134	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	55,134	0	0	0	0	0	0	0	0	0	55,134	16
	C. General Administration													
17	Administrative	0	(132,000)	124,398	0	0	0	0	0	0	0	0	(7,602)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	41,380	0	0	0	0	0	0	0	0	41,380	19
20	Fees, Subscriptions & Promotions	(9,292)	0	793	0	0	0	0	0	0	0	0	(8,499)	20
21	Clerical & General Office Expenses	(71,638)	0	237,776	0	0	0	0	0	0	0	0	166,138	21
22	Employee Benefits & Payroll Taxes	0	0	27,949	0	0	0	0	0	0	0	0	27,949	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	13,948	0	0	0	0	0	0	0	0	13,948	25
26	Insurance-Prop.Liab.Malpractice	0	0	9,837	0	0	0	0	0	0	0	0	9,837	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(80,930)	(132,000)	456,081	0	243,151	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(85,650)	(76,866)	475,225	0	312,709	29							

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	\$ 132,000	HSM Management Services, Inc.	100.00%	\$	\$ (132,000)
2	V						
3	V	10a Therapy	422,314	Rosewood Therapy Services, Inc.	0.00%	477,448	55,134
4	V						
5	V	34 Rent	784,200	Rockford Real Estate, L.L.C.	0.00%		(784,200)
6	V	30 Depreciation		Rockford Real Estate, L.L.C.		206,459	206,459
7	V	32 Interest		Rockford Real Estate, L.L.C.		467,484	467,484
8	V	32 Amortization - Loan Fee		Rockford Real Estate, L.L.C.		36,307	36,307
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 1,338,514			\$ 1,187,698	\$ * (150,816)

* 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%	\$ 124,398	\$ 124,398
16	V	21 See Schedule VIII		HSM Management Services, Inc.	100.00%	237,776	237,776
17	V	22 See Schedule VIII		HSM Management Services, Inc.	100.00%	27,949	27,949
18	V	25 See Schedule VIII		HSM Management Services, Inc.	100.00%	13,948	13,948
19	V	30 See Schedule VIII		HSM Management Services, Inc.	100.00%	23,166	23,166
20	V	34 See Schedule VIII		HSM Management Services, Inc.	100.00%	11,510	11,510
21	V	19 See Schedule VIII		HSM Management Services, Inc.	100.00%	41,380	41,380
22	V	26 See Schedule VIII		HSM Management Services, Inc.	100.00%	9,837	9,837
23	V	6 See Schedule VIII		HSM Management Services, Inc.	100.00%	18,941	18,941
24	V	5 See Schedule VIII		HSM Management Services, Inc.	100.00%	203	203
25	V	20 See Schedule VIII		HSM Management Services, Inc.	100.00%	793	793
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		\$			\$ 509,901	\$ * 509,901

* 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: 7/1/2002 Ending: 6/30/2003

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%	607,712	3	6.48%	Salary	\$ 42,102	17-3	1
2	Darrell Hoefling	Vice-President	Management	25.00%	332,521	3	6.48%	Salary	23,037	17-3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 65,139		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: 7/1/2002 Ending: 3/30/2003

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	78,214,895	17	\$ 1,005,371	\$ 5,067,629	\$ 65,139	1
2	21	Salaries - Others	Total Cost	78,214,895	17	3,183,939	5,067,629	206,291	2
3	22	Payroll Taxes	Total Cost	78,214,895	17	296,707	5,067,629	19,224	3
4	22	Employee Benefits	Total Cost	78,214,895	17	59,110	5,067,629	3,830	4
5	25	Travel	Total Cost	78,214,895	17	207,136	5,067,629	13,421	5
6	30	Depreciation	Total Cost	78,214,895	17	351,450	5,067,629	22,771	6
7	34	Building Rent	Total Cost	78,214,895	17	177,648	5,067,629	11,510	7
8	19	Professional Services	Total Cost	78,214,895	17	638,666	5,067,629	41,380	8
9	21	Telephone	Total Cost	78,214,895	17	223,118	5,067,629	14,456	9
10	26	Insurance	Total Cost	78,214,895	17	151,827	5,067,629	9,837	10
11	21	Taxes, Licenses, & Ofc Sup	Total Cost	78,214,895	17	262,831	5,067,629	17,029	11
12	6	Maintenance	Total Cost	78,214,895	17	283,265	5,067,629	18,353	12
13	5	Heat & Other Utilities	Total Cost	78,214,895	17	3,126	5,067,629	203	13
14	20	Dues & Subscriptions	Total Cost	78,214,895	17	12,246	5,067,629	793	14
15	17	Direct - Admin	Direct Cost	1	1	59,259	1	59,259	15
16	17	Direct - Admin	Direct Cost	15	15	876,742	0	0	16
17	22	Direct - Payroll Taxes	Direct Cost	1	1	4,895	1	4,895	17
18	22	Direct - Payroll Taxes	Direct Cost	15	15	76,361	0	0	18
19	30	Direct - Depreciation	Direct Cost	1	1	395	1	395	19
20	30	Direct - Depreciation	Direct Cost	13	13	11,758	0	0	20
21	25	Direct - Travel	Direct Cost	1	1	527	1	527	21
22	25	Direct - Travel	Direct Cost	11	11	17,234	0	0	22
23	6	Direct - Maintenance	Direct Cost	1	1	588	1	588	23
24	6	Direct - Maintenance	Direct Cost	13	13	5,603	0	0	24
25	TOTALS					\$ 7,909,802	\$ 5,125,311	\$ 509,901	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Rockford # 0041756 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

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		Commerce Bank		X	Refinance	Varies	4/12/02	\$ 11,000,000	\$ 11,000,000		5.03%	\$ 509,868	1						
2		Less: Related Party Interest Income Offset										(42,384)	2						
3		Amortization of Loan Costs										36,307	3						
4		Interest Income										(3,991)	4						
5													5						
		Working Capital																	
6													6						
7													7						
8													8						
9		TOTAL Facility Related						\$ 11,000,000	\$ 11,000,000			\$ 499,800	9						
		B. Non-Facility Related*																	
10													10						
11													11						
12													12						
13													13						
14		TOTAL Non-Facility Related						\$	\$			\$	14						
15		TOTALS (line 9+line14)						\$ 11,000,000	\$ 11,000,000			\$ 499,800	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 Line # N/A

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

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

Facility Name & ID Number **Rosewood Care Center Rockford**# **0041756** Report Period Beginning: **7/1/2002** Ending: **6/30/2003****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 2002 report.			\$	91,339	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.)			\$	51,939	2	
3.	Under or (over) accrual (line 2 minus line 1).			\$	(39,400)	3	
4.	Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	160,764	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.)			\$	1,500	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.			\$	122,864	7	
Real Estate Tax History:							
Real Estate Tax Bill for Calendar Year:		1998	107,881	8	FOR OHF USE ONLY		
		1999	107,053	9			
		2000	101,600	10	13	FROM R. E. TAX STATEMENT FOR 2002 \$ 13	
		2001	103,877	11	14	PLUS APPEAL COST FROM LINE 5 \$ 14	
		2002	106,467	12	15	LESS REFUND FROM LINE 6 \$ 15	
2001 Payment - \$51,939						16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
Accrual = Balance of 2002 tax bill (106,467) + 1/2 of estimated 2003 tax bill (54,298)							

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:** 2002 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 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 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 2003 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.

2002 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 2002 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 2002.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>12-34-101-028</u>	<u>Rosewood Sub Pt NW1/4</u>	\$ <u>4,946.80</u>	\$ <u>4,946.80</u>
2. _____	<u>Sec 34-44-2 Lot 2</u>	\$ _____	\$ _____
3. <u>12-34-102-022</u>	<u>Rosewood Sub Pt NW1/4</u>	\$ <u>101,519.74</u>	\$ <u>101,519.74</u>
4. _____	<u>Sec 34-44-2 Lot 1</u>	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>106,466.54</u>	\$ <u>106,466.54</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 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Rosewood Care Center Rockford# 0041756 Report Period Beginning:7/1/2002 Ending:6/30/2003

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:

7/1/2002

Ending:

6/30/2003**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	\$ 661,498	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Left Turn Lane Street	1996		50,239		25	2,010	2,010	14,405	9
10		Parking Lot Paving	1996		95,573		25	3,823	3,823	27,398	10
11		Site Excavation	1996		83,290		25	3,332	3,332	23,879	11
12		Storm & Sanitary Sewers, and Site Water Line	1996		154,171		25	6,167	6,167	44,197	12
13		Sprinkler System	1996		24,160		25	966	966	6,923	13
14		Landscaping	1996		55,477		25	2,219	2,219	15,903	14
15		Architect Fees	1996		35,224		25	1,409	1,409	10,098	15
16		Site Work	1996		9,428		25	377	377	2,702	16
17		Contractor Fee	1996		21,047		25	842	842	6,034	17
18		Title Fee	1996		1,068		25	43	43	308	18
19		Builder's Risk	1996		2,159		25	86	86	616	19
20		Legal Fees	1996		1,851		25	74	74	530	20
21		Construction Interest	1996		29,594		25	1,184	1,184	8,485	21
22		Outdoor Signs, Monument Sign, and Facility Signage	1996		14,259		10	1,426	1,426	10,220	22
23		Water Heater/Boiler/Hot Water Booster	1996		16,147		10	1,615	1,615	11,574	23
24		Emergency Generator	1996		29,359		10	2,936	2,936	21,041	24
25		Walk-in Cooler	1996		5,094		10	509	509	3,648	25
26		Alarm Annunciator, Fire Alarm System, Door Alarm	1996		29,030		10	2,903	2,903	20,805	26
27		Wallcovering & Painting	1996		67,810		10	6,781	6,781	48,597	27
28		Kitchen Exhaust Hoods	1996		6,883		10	688	688	4,931	28
29		Sinks/Drains	1996		6,712		10	671	671	4,809	29
30		Nurse Call System	1996		28,100		10	2,810	2,810	20,138	30
31		TV Cable& Antenna, Telephone & Paging Wiring	1996		70,140		10	7,014	7,014	50,267	31
32		Carpet	1996		8,915		10	892	892	6,393	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:

7/1/2002

Ending:

6/30/2003

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:								
38	Office Construction/Improvements	1995	496		5			496	38
39	Office Design	1995	45		5			45	39
40	Office Shelving	1996	106		4			106	40
41	Office Expansion	1996	468		4			468	41
42	Office Expansion	1997	1,254		3			1,254	42
43	Office Expansion	1998	707		3			707	43
44	Office Addition	1999	349		3			349	44
45	Door Locks	1999	174		3	24	24	174	45
46									46
47									47
48									48
49									49
50	Leasehold Improvements - Facility:								
51	Computer Cabling	2000	2,392	341	7	341		883	51
52	Cubicles	2003	7,942	473	7	473		473	52
53	Carpet	2003	5,800	138	7	138		138	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)		\$ 4,557,555	\$ 952		\$ 144,055	\$ 143,103	\$ 1,030,492	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	\$ 733,462	\$ 2,620	\$ 80,685	\$ 78,065	5-10 Yrs	\$ 486,322	71
72	Current Year Purchases	4,939	25	187	162	10 Yrs	187	72
73	Fully Depreciated Assets	44,116					44,116	73
74								74
75	TOTALS	\$ 782,517	\$ 2,645	\$ 80,872	\$ 78,227		\$ 530,625	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	\$ 29,680	\$	\$ 8,295	\$ 8,295	4 Yrs	\$ 14,618	76
77										77
78										78
79										79
80	TOTALS			\$ 29,680	\$	\$ 8,295	\$ 8,295		\$ 14,618	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)	\$ 5,632,226	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 3,597	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 233,222	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 229,625	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,575,735	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>/2004</u>	\$ _____
13.	<u>/2005</u>	\$ _____
14.	<u>/2006</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	\$	14,670	\$	186,992	\$			14,670	\$	186,992	1
2	Licensed Speech and Language Development Therapist	10a-8	hrs		2,178		34,816				2,178		34,816	2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist	10a-8	hrs		20,691		255,640		1,471		20,691		257,111	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						193,115				193,115	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Exceptional Care Program													12
13	Ambulance, Laboratory, Enterals, Other (specify): & X-Ray	39-8					21,851		19,452				41,303	13
14	TOTAL			\$	37,539	\$	499,299	\$	214,038		37,539	\$	713,337	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: 7/1/2002

Ending:

6/30/2003

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2003

(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	\$ 576,934	1
2	Cash-Patient Deposits		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 114,000)	1,043,690	3
4	Supply Inventory (priced at)		4
5	Short-Term Investments		5
6	Prepaid Insurance	3,130	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)	\$ 1,623,754	10
B. Long-Term Assets			
11	Long-Term Notes Receivable		11
12	Long-Term Investments		12
13	Land		13
14	Buildings, at Historical Cost	34,768	14
15	Leasehold Improvements, at Historical Cost		15
16	Equipment, at Historical Cost		16
17	Accumulated Depreciation (book methods)	(7,256)	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)	\$ 27,512	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,651,266	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26	Accounts Payable	\$ 215,482	26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits		28
29	Short-Term Notes Payable	199,103	29
30	Accrued Salaries Payable	214,710	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,373	31
32	Accrued Real Estate Taxes(Sch.IX-B)	160,764	32
33	Accrued Interest Payable		33
34	Deferred Compensation		34
35	Federal and State Income Taxes		35
Other Current Liabilities(specify):			
36			36
37	Accrued Rent	1,003,820	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,810,252	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)	\$ 1,810,252	46
47	TOTAL EQUITY(page 18, line 24)	\$ (158,986)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,651,266	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (179,660)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (179,660)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	20,674	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)	\$ 20,674	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)	\$ (158,986)	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	\$ 5,815,236	1
2	Discounts and Allowances for all Levels	(1,822,387)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,992,849	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,637,430	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,637,430	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	3,875	13
14	Non-Patient Meals	4,476	14
15	Telephone, Television and Radio	13,771	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)	\$ 22,122	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	3,991	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,991	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Lab Discounts	2,097	28
28a	Miscellaneous	1,020	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,117	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,659,509	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	761,455	31
32	Health Care	2,894,417	32
33	General Administration	715,807	33
B. Capital Expense			
34	Ownership	959,724	34
C. Ancillary Expense			
35	Special Cost Centers	236,515	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)*	\$ 5,633,618	40
41	Income before Income Taxes (line 30 minus line 40)**	25,891	41
42	Income Taxes	(5,217)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 20,674	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: **7/1/2002**Ending: **6/30/2003**

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	2,173	2,280	\$ 66,786	\$ 29.29	1
2	Assistant Director of Nursing	2,080	2,183	54,572	25.00	2
3	Registered Nurses	11,024	11,571	246,129	21.27	3
4	Licensed Practical Nurses	20,952	21,991	413,981	18.83	4
5	Nurse Aides & Orderlies	63,238	66,373	715,494	10.78	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,248	4,458	63,074	14.15	8
9	Activity Director					9
10	Activity Assistants	4,948	5,193	45,120	8.69	10
11	Social Service Workers	3,824	4,013	41,793	10.41	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,178	21,178	184,691	8.72	15
16	Dishwashers					16
17	Maintenance Workers	2,186	2,295	28,314	12.34	17
18	Housekeepers	15,858	16,644	124,311	7.47	18
19	Laundry	5,136	5,390	36,111	6.70	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,234	13,891	159,746	11.50	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	6,653	6,983	92,927	13.31	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	175,732	184,443	\$ 2,273,049 *	\$ 12.32	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	380	\$ 8,798	1-3	35
36	Medical Director	Contract	13,003	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	80	2,000	11-3	44
45	Social Service Consultant	85	2,200	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	545	\$ 26,001		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	3,820	\$ 171,578	10-3	50
51	Licensed Practical Nurses	10,416	375,332	10-3	51
52	Nurse Aides	203	4,201	10-3	52
53	TOTAL (lines 50 - 52)	14,439	\$ 551,111		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									
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	
1	Schedule Not Applicable		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	
2														
3														
4														
5														
6														
7														
8														
9														
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11														
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16														
17														
18														
19														
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Rockford# 0041756Report Period Beginning: 7/1/2002Ending: 6/30/2003**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. \$ 43,875 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. \$ 4,476
- (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. Copy attached to RCC-East Peoria
- (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 ROCKFORD
IDPH ID #0041756
ATTACHMENT TO SCHEDULE V, LINE 25
6/30/2003

OTHER ADMIN. STAFF TRANSPORTATION:

MILEAGE REIMBURSEMENT**	<u>\$ 5,574</u>
	<u>\$ 5,574</u>

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

ROSEWOOD CARE CENTER INC. OF ROCKFORD
IDPH ID #0041756
ATTACHMENT TO SCHEDULE VII, SECTION A.
6/30/2003

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 ELGIN	ELGIN, IL
ROSEWOOD CARE CENTER OF GALESBURG	GALESBURG, IL
ROSEWOOD CARE CENTER OF INVERNESS	INVERNESS, IL
ROSEWOOD CARE CENTER OF JOLIET	JOLIET, IL
ROSEWOOD CARE CENTER OF MOLINE	MOLINE, IL
ROSEWOOD CARE CENTER OF NORTHBROOK	NORTHBROOK, IL
ROSEWOOD CARE CENTER OF PEORIA	PEORIA, 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.
ROCKFORD REAL ESTATE, INC.	REAL ESTATE LSG.
HSM DEVELOPMENT, INC.	DEVELOPMENT CO.
RCC HOLDING COMPANY	HOLDING COMPANY
ROSEWOOD HOME HEALTH	HOME HEALTH CO.
ROSEWOOD THERAPY SERVICES	THERAPY COMPANY