

Facility Name & ID Number Rosewood Care Ctr Northbrook

0042341 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>147</u>	Skilled (SNF)	<u>147</u>	<u>53,655</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>147</u>	TOTALS	<u>147</u>	<u>53,655</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	Other		
8	SNF			<u>2,084</u>	<u>2,084</u>	8
9	SNF/PED					9
10	ICF	<u>21,094</u>	<u>8,456</u>		<u>29,550</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>21,094</u>	<u>8,456</u>	<u>2,084</u>	<u>31,634</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.96%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 6/22/98

J. Was the facility purchased or leased after January 1, 1978?
YES Date 6/22/98 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 48 and days of care provided 2,084

Medicare Intermediary Tri-Span

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/03 Fiscal Year: 6/30/03

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

STATE OF ILLINOIS

Facility Name & ID Number Rosewood Care Ctr Northbrook # 0042341 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	235,949	23,450	5,546	264,945	264,945		264,945			1
2	Food Purchase		156,191		156,191	156,191	(4,570)	151,621			2
3	Housekeeping	167,931	28,793		196,724	196,724		196,724			3
4	Laundry	42,798	15,947		58,745	58,745		58,745			4
5	Heat and Other Utilities			162,564	162,564	162,564	204	162,768			5
6	Maintenance	26,991	10,565	107,523	145,079	145,079	18,880	163,959			6
7	Other (specify):* Sanitation			8,239	8,239	8,239		8,239			7
8	TOTAL General Services	473,669	234,946	283,872	992,487	992,487	14,514	1,007,001			8
B. Health Care and Programs											
9	Medical Director			850	850	850		850			9
10	Nursing and Medical Records	2,075,808	147,920		2,223,728	2,223,728		2,223,728			10
10a	Therapy	94,602	1,463	151,909	247,974	247,974	46,845	294,819			10a
11	Activities	53,369	4,405	2,533	60,307	60,307		60,307			11
12	Social Services	60,473		2,306	62,779	62,779		62,779			12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,284,252	153,788	157,598	2,595,638	2,595,638	46,845	2,642,483			16
C. General Administration											
17	Administrative			161,700	161,700	161,700	(52,138)	109,562			17
18	Directors Fees										18
19	Professional Services			5,579	5,579	5,579	41,733	47,312			19
20	Dues, Fees, Subscriptions & Promotions			41,376	41,376	41,376	(9,818)	31,558			20
21	Clerical & General Office Expenses	158,561	21,199	29,874	209,634	209,634	182,590	392,224			21
22	Employee Benefits & Payroll Taxes			328,843	328,843	328,843	27,440	356,283			22
23	Inservice Training & Education										23
24	Travel and Seminar			751	751	751		751			24
25	Other Admin. Staff Transportation			4,695	4,695	4,695	13,996	18,691			25
26	Insurance-Prop.Liab.Malpractice			59,830	59,830	59,830	9,921	69,751			26
27	Other (specify):*										27
28	TOTAL General Administration	158,561	21,199	632,648	812,408	812,408	213,724	1,026,132			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,916,482	409,933	1,074,118	4,400,533	4,400,533	275,083	4,675,616			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Rosewood Care Ctr Northbrook

#0042341

Report Period Beginning:

7/1/2002

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			871	871		871	373,190	374,061			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			448,908	448,908		448,908	(132,228)	316,680			32
33	Real Estate Taxes			148,264	148,264		148,264		148,264			33
34	Rent-Facility & Grounds			862,498	862,498		862,498	(850,890)	11,608			34
35	Rent-Equipment & Vehicles			1,988	1,988		1,988		1,988			35
36	Other (specify):*											36
37	TOTAL Ownership			1,462,529	1,462,529		1,462,529	(609,928)	852,601			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		64,595	3,760	68,355		68,355	(467)	67,888			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			80,483	80,483		80,483		80,483			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		64,595	84,243	148,838		148,838	(467)	148,371			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,916,482	474,528	2,620,890	6,011,900		6,011,900	(335,312)	5,676,588			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr Northbrook

0042341

Report Period Beginning: 7/1/2002

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	(4,381)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,787)	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	(2,013)	32		10
11	Discounts, Allowances, Rebates & Refunds	(467)	39		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(189)	2		13
14	Non-Care Related Interest	(448,908)	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	(2,312)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(5,306)	20		28
29	Other-Attach Schedule Marketing Salary	(55,426)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (523,789)		\$	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
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	188,477	Var	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 188,477		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (335,312)		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 Ctr Northbrook

ID# 0042341
 Report Period Beginning: 7/1/2002
 Ending: 6/30/2003

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$ (55,426)	21
2			
3			
4			
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49	Total	(55,426)	

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Ctr Northbrook

0042341 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	(4,570)	0	0	0	0	0	0	0	0	0	0	(4,570)	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	204	0	0	0	0	0	0	0	0	204	5
6	Maintenance	0	0	18,880	0	0	0	0	0	0	0	0	18,880	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(4,570)	0	19,084	0	14,514	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	46,845	0	0	0	0	0	0	0	0	0	46,845	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	46,845	0	0	0	0	0	0	0	0	0	46,845	16
	C. General Administration													
17	Administrative	0	(161,700)	109,562	0	0	0	0	0	0	0	0	(52,138)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	41,733	0	0	0	0	0	0	0	0	41,733	19
20	Fees, Subscriptions & Promotions	(10,618)	0	800	0	0	0	0	0	0	0	0	(9,818)	20
21	Clerical & General Office Expenses	(57,213)	0	239,803	0	0	0	0	0	0	0	0	182,590	21
22	Employee Benefits & Payroll Taxes	0	0	27,440	0	0	0	0	0	0	0	0	27,440	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	13,996	0	0	0	0	0	0	0	0	13,996	25
26	Insurance-Prop.Liab.Malpractice	0	0	9,921	0	0	0	0	0	0	0	0	9,921	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(67,831)	(161,700)	443,255	0	213,724	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(72,401)	(114,855)	462,339	0	275,083	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Ctr Northbrook# 0042341

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

	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	349,209	23,981	0	0	0	0	0	0	0	0	373,190 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(450,921)	318,693	0	0	0	0	0	0	0	0	0	(132,228) 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	(862,498)	11,608	0	0	0	0	0	0	0	0	(850,890) 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	(450,921)	(194,596)	35,589	0	(609,928) 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	(467)	0	0	0	0	0	0	0	0	0	0	(467) 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	(467)	0	0	0	0	0	0	0	0	0	0	(467) 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(523,789)	(309,451)	497,928	0	(335,312) 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	\$ 161,700	HSM Management Services, Inc.	100.00%	\$	\$ (161,700)
2	V						
3	V	10a Therapy	151,909	Rosewood Therapy Services, Inc.	0.00%	198,754	46,845
4	V						
5	V	34 Rent	862,498	Northbrook Real Estate, Inc.	0.00%		(862,498)
6	V	30 Depreciation		Northbrook Real Estate, Inc.		349,209	349,209
7	V	32 Interest		Northbrook Real Estate, Inc.		310,029	310,029
8	V	32 Amortization - Loan Fee		Northbrook Real Estate, Inc.		8,664	8,664
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 1,176,107			\$ 866,656	\$ * (309,451)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 See Schedule VIII	\$	HSM Management Services, Inc.	100.00%	\$ 109,562	\$ 109,562
16	V	21 See Schedule VIII		HSM Management Services, Inc.	100.00%	239,803	239,803
17	V	22 See Schedule VIII		HSM Management Services, Inc.	100.00%	27,440	27,440
18	V	25 See Schedule VIII		HSM Management Services, Inc.	100.00%	13,996	13,996
19	V	30 See Schedule VIII		HSM Management Services, Inc.	100.00%	23,981	23,981
20	V	34 See Schedule VIII		HSM Management Services, Inc.	100.00%	11,608	11,608
21	V	19 See Schedule VIII		HSM Management Services, Inc.	100.00%	41,733	41,733
22	V	26 See Schedule VIII		HSM Management Services, Inc.	100.00%	9,921	9,921
23	V	6 See Schedule VIII		HSM Management Services, Inc.	100.00%	18,880	18,880
24	V	5 See Schedule VIII		HSM Management Services, Inc.	100.00%	204	204
25	V	20 See Schedule VIII		HSM Management Services, Inc.	100.00%	800	800
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		\$			\$ 497,928	\$ * 497,928

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

Facility Name & ID Number Rosewood Care Ctr Northbrook # 0042341 Report Period Beginning: 7/1/2002 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	607,353	3	6.53%	Salary	\$ 42,461	17-8	1
2	Darrell Hoefling	Vice-President	Management	25.00	332,324	3	6.53%	Salary	23,234	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	\$ 65,695		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr Northbrook # 0042341 Report Period Beginning: 7/1/2002 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	\$ 5,110,839	\$ 65,695	1
2	21	Salaries - Others	Total Cost	78,214,895	17	3,183,939	5,110,839	208,050	2
3	22	Payroll Taxes	Total Cost	78,214,895	17	296,707	5,110,839	19,388	3
4	22	Employee Benefits	Total Cost	78,214,895	17	59,110	5,110,839	3,862	4
5	25	Travel	Total Cost	78,214,895	17	207,136	5,110,839	13,535	5
6	30	Depreciation	Total Cost	78,214,895	17	351,450	5,110,839	22,965	6
7	34	Building Rent	Total Cost	78,214,895	17	177,648	5,110,839	11,608	7
8	19	Professional Services	Total Cost	78,214,895	17	638,666	5,110,839	41,733	8
9	21	Telephone	Total Cost	78,214,895	17	223,118	5,110,839	14,579	9
10	26	Insurance	Total Cost	78,214,895	17	151,827	5,110,839	9,921	10
11	21	Taxes, Licenses, Office Supplies	Total Cost	78,214,895	17	262,831	5,110,839	17,174	11
12	6	Maintenance	Total Cost	78,214,895	17	283,265	5,110,839	18,510	12
13	5	Heat & Other Utilities	Total Cost	78,214,895	17	3,126	5,110,839	204	13
14	20	Dues & Subscriptions	Total Cost	78,214,895	17	12,246	5,110,839	800	14
15	17	Direct - Admin	Direct Cost	1	1	43,867	1	43,867	15
16	17	Direct - Admin	Direct Cost	15	15	892,134	0	0	16
17	22	Direct - Payroll Taxes	Direct Cost	1	1	4,190	1	4,190	17
18	22	Direct - Payroll Taxes	Direct Cost	15	15	77,066	0	0	18
19	30	Direct - Depreciation	Direct Cost	1	1	1,016	1	1,016	19
20	30	Direct - Depreciation	Direct Cost	13	13	11,137	0	0	20
21	25	Direct - Travel	Direct Cost	1	1	461	1	461	21
22	25	Direct - Travel	Direct Cost	11	11	17,300	0	0	22
23	6	Direct - Maintenance	Direct Cost	1	1	370	1	370	23
24	6	Direct - Maintenance	Direct Cost	13	13	5,821	0	0	24
25	TOTALS					\$ 7,909,802	\$ 5,125,311	\$ 497,928	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr Northbrook # 0042341 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	2	3	4	5	6		7	8	9	10									
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
	A. Directly Facility Related																			
	Long-Term																			
1	US Bank		X	Mortgage	Varies	6/98	\$ 7,793,081	\$ 0		Prm + 1/2	\$ 246,908	1								
2	Allegiant Bank		X	Refinance Mortgage	Varies	2/03	6,700,000	6,700,000	2/05	LIBOR+2.75%	89,933	2								
3	Less: Related Party Interest Income Offset											(26,812)	3							
4	Amortization of Loan Fees											8,664	4							
5	Interest Income											(2,013)	5							
	Working Capital																			
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 14,493,081	\$ 6,700,000			\$ 316,680	9								
	B. Non-Facility Related*																			
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 14,493,081	\$ 6,700,000			\$ 316,680	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 Ctr Northbrook**# **0042341** 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.			\$	207,823	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.)			\$	206,247	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	(1,576)	3
4.	Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	149,840	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.			\$	148,264	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		1998	84,000	8	FOR OHF USE ONLY	
		1999	87,636	9		
		2000	118,050	10	13	FROM R. E. TAX STATEMENT FOR 2002 \$ 13
		2001	176,848	11	14	PLUS APPEAL COST FROM LINE 5 \$ 14
		2002	157,789	12	15	LESS REFUND FROM LINE 6 \$ 15
	2001 Payment \$117,823				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
	2002 Payment \$88,424					
	Accrual = Remainder of 2002 tax bill owed (69,365) + 1/2 of 2003 estimated tax (80,475)					

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 Ctr Northbrook COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042341

CONTACT PERSON REGARDING THIS REPORT Chuck Schmitz

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

A. Summary of Real Estate Tax 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)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>04-06-101-006-0000</u>	<u>4101 Lake Cook Rd, Northbrook</u>	\$ <u>74,172.89</u>	\$ <u>74,172.89</u>
2. <u>04-06-101-007-0000</u>	<u>4101 Kingston Rd, Northbrook</u>	\$ <u>83,616.21</u>	\$ <u>83,616.21</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>157,789.10</u>	\$ <u>157,789.10</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 Ctr Northbrook# 0042341 Report Period Beginning:7/1/2002 Ending:6/30/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 63,834 B. General Construction Type: Exterior Brick Veneer Frame Steel Number of Stories 2C. 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>6.6 Acres</u>	<u>1998</u>	<u>\$ 1,313,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	#VALUE!		\$ 1,313,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr Northbrook# 0042341

Report Period Beginning:

7/1/2002

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	147		1998		\$ 8,660,744	\$	25-40	\$ 236,043	\$ 236,043	\$ 1,181,273	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Leasehold Improvements - Management Company:										
10			1995		500		5			500	10
11			1995		46		5			46	11
12			1996		107		4			107	12
13			1996		472		4			472	13
14			1997		1,264		3			1,264	14
15			1998		713		3			713	15
16			1999		352		3			352	16
17			1999		176		3	24	24	176	17
18											18
19	Facility Leaseholds:										
20			2001		3,230	461	7	461		1,152	20
21			2002		2,870	410	7	410		547	21
22											22
23											23
24											24
25			1998		1,900		7	271	271	1,450	25
26			1998		54,214		7	7,745	7,745	37,498	26
27			1998		21,364		7	3,051	3,051	14,772	27
28			1998		11,679		7	1,668	1,668	8,077	28
29			1998		3,833		7	548	548	2,652	29
30			1998		9,661		7	1,380	1,380	6,682	30
31			1998		23,313		7	3,330	3,330	16,123	31
32			1998		37,340		7	5,334	5,334	25,826	32
33			1998		74,806		7	10,687	10,687	51,744	33
34			1998		22,221		7	3,174	3,174	15,368	34
35			1998		46,099		7	6,586	6,586	31,887	35
36			1998		12,549		7	1,793	1,793	8,681	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

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			\$	\$		\$	\$	\$		37
38										38
39										39
40										40
41										41
42										42
43										43
44										44
45										45
46										46
47										47
48										48
49										49
50										50
51										51
52										52
53										53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 8,989,453	\$ 871		\$ 282,505	\$ 281,634	\$ 1,407,362		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	\$ 567,940	\$	\$ 82,242	\$ 82,242	5-10 Yrs	\$ 402,824	71
72	Current Year Purchases	17,492		948	948	10 Yrs	948	72
73	Fully Depreciated Assets	35,652					35,652	73
74								74
75	TOTALS	\$ 621,084	\$	\$ 83,190	\$ 83,190		\$ 439,424	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	\$ 29,933	\$	\$ 8,366	\$ 8,366	4 Yrs	\$ 14,742	76
77										77
78										78
79										79
80	TOTALS			\$ 29,933	\$	\$ 8,366	\$ 8,366		\$ 14,742	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)	\$ 10,953,470	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 871	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 374,061	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 373,190	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,861,528	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. _____/2004 \$ _____
13. _____/2005 \$ _____
14. _____/2006 \$ _____

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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$	5,993	\$ 101,525	\$	5,993	\$ 101,525	1
2	Licensed Speech and Language Development Therapist		hrs		606	5,585		606	5,585	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		6,904	91,644	1,463	6,904	93,107	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				46,152		46,152	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				3,293	18,443		21,736	13
14	TOTAL			\$	13,503	\$ 202,047	\$ 66,058	13,503	\$ 268,105	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 Ctr Northbrook

0042341

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	\$ 133,571	1
2	Cash-Patient Deposits		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 74,000)	726,948	3
4	Supply Inventory (priced at)		4
5	Short-Term Investments		5
6	Prepaid Insurance	4,290	6
7	Other Prepaid Expenses	2,423	7
8	Accounts Receivable (owners or related parties)	269,854	8
9	Other(specify):		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,137,086	10
B. Long-Term Assets			
11	Long-Term Notes Receivable		11
12	Long-Term Investments		12
13	Land		13
14	Buildings, at Historical Cost	6,100	14
15	Leasehold Improvements, at Historical Cost		15
16	Equipment, at Historical Cost		16
17	Accumulated Depreciation (book methods)	(1,700)	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)	\$ 4,400	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,141,486	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26	Accounts Payable	\$ 141,911	26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits		28
29	Short-Term Notes Payable	10,365,854	29
30	Accrued Salaries Payable	236,888	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,380	31
32	Accrued Real Estate Taxes(Sch.IX-B)	149,840	32
33	Accrued Interest Payable		33
34	Deferred Compensation		34
35	Federal and State Income Taxes		35
Other Current Liabilities(specify):			
36			36
37			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 10,907,873	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)	\$ 10,907,873	46
47	TOTAL EQUITY(page 18, line 24)	\$ (9,766,387)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,141,486	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (8,329,781)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (8,329,781)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,436,606)	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)	\$ (1,436,606)	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)	\$ (9,766,387)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr Northbrook

0042341

Report Period Beginning: 7/1/2002

Ending: 6/30/2003

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	\$ 4,656,741	1
2	Discounts and Allowances for all Levels	(570,594)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,086,147	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	476,780	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 476,780	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	3,255	13
14	Non-Patient Meals	4,381	14
15	Telephone, Television and Radio	1,787	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)	\$ 9,423	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,013	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,013	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Lab Discounts	467	28
28a	Miscellaneous	464	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 931	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,575,294	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	992,487	31
32	Health Care	2,595,638	32
33	General Administration	812,408	33
B. Capital Expense			
34	Ownership	1,462,529	34
C. Ancillary Expense			
35	Special Cost Centers	68,355	35
36	Provider Participation Fee	80,483	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,011,900	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,436,606)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,436,606)	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 Ctr Northbrook**

0042341

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	2,101	2,190	\$ 67,317	\$ 30.74	1
2	Assistant Director of Nursing	1,151	1,200	33,711	28.09	2
3	Registered Nurses	35,178	36,672	1,093,965	29.83	3
4	Licensed Practical Nurses	771	804	15,942	19.83	4
5	Nurse Aides & Orderlies	65,365	68,141	836,853	12.28	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,089	4,263	94,602	22.19	8
9	Activity Director					9
10	Activity Assistants	5,231	5,454	53,369	9.79	10
11	Social Service Workers	3,977	4,145	60,473	14.59	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,567	23,525	235,949	10.03	15
16	Dishwashers					16
17	Maintenance Workers	2,074	2,162	26,991	12.48	17
18	Housekeepers	18,667	19,460	167,931	8.63	18
19	Laundry	4,963	5,174	42,798	8.27	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,378	12,904	158,561	12.29	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	2,224	2,319	28,020	12.08	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	180,736	188,413	\$ 2,916,482 *	\$ 15.48	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	230	\$ 5,546	1-3	35
36	Medical Director	Contract	850	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	2,233	11-3	44
45	Social Service Consultant	80	2,306	12-3	45
46	Other(specify) <u>Pastoral Services</u>	N/A	300	11-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	390	\$ 11,235		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ Section N/A		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									
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	
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 Ctr Northbrook# 0042341Report 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. \$ 70,230 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. \$ 80,483
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. \$ 4,381
- (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 NORTHBROOK
IDPH ID #0042341
ATTACHMENT TO SCHEDULE V, LINE 25
6/30/2003

OTHER ADMIN. STAFF TRANSPORTATION:

MILEAGE REIMBURSEMENT**	<u>\$ 4,695</u>
	<u><u>\$ 4,695</u></u>

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

ROSEWOOD CARE CENTER INC. OF NORTHBROOK
IDPH ID #0042341
ATTACHMENT TO SCHEDULE VII, SECTION A.
6/30/2003

RELATED NURSING HOME:

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

CITY:

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

OTHER RELATED BUSINESS ENTITIES:

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

TYPE OF BUSINESS:

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