

		FOR BHF USE					

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**2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)**

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

<p>I. IDPH License ID Number: <u>0049791</u></p> <p>Facility Name: <u>ROSEWOOD CARE CENTER GALESBURG</u></p> <p>Address: <u>1250 W. Carl Sandburg Dr.</u> <u>Galesburg</u> <u>61401</u> <small>Number City Zip Code</small></p> <p>County: <u>Knox</u></p> <p>Telephone Number: <u>(309)344-5400</u> <small>Fax #</small> _____</p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>5/1/2008</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code _____</td> <td style="border: none;"><input checked="" type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Cindy A. Tefteller</u> Telephone Number: <u>(618)465-7717</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/10</u> to <u>6/30/11</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px; vertical-align: top;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td style="padding: 5px; vertical-align: top;">Paid Preparer</td> <td style="padding: 5px;">(Signed) <u>See Accountant's Compilation Report</u> (Print Name and Title) <u>Cindy A. Tefteller</u> (Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C. 233 East Center Drive, Alton, IL 62002</u> (Telephone) <u>(618)465-7717</u> Fax # <u>(618)465-7710</u></td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) <u>See Accountant's Compilation Report</u> (Print Name and Title) <u>Cindy A. Tefteller</u> (Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C. 233 East Center Drive, Alton, IL 62002</u> (Telephone) <u>(618)465-7717</u> Fax # <u>(618)465-7710</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROSEWOOD CARE CENTER GALESBURG# 0049791 Report Period Beginning: 7/1/10 Ending: 6/30/11

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	180	Skilled (SNF)	180	65,700	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	180	TOTALS	180	65,700	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF			3,996	3,996	8
9	SNF/PED					9
10	ICF	21,752	9,704		31,456	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,752	9,704	3,996	35,452	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 53.96%D. How many bed-hold days during this year were paid by the Department? 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)
NoneF. Does the facility maintain a daily midnight census? YesG. 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 5/1/2008J. Was the facility purchased or leased after January 1, 1978?
YES Date 5/1/2008 NO K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 180 and days of care provided 3,996Medicare Intermediary Pinnacle Business Solutions, Inc.

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 6/30/11 Fiscal Year: 6/30/11

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **ROSEWOOD CARE CENTER GALESBURG** # **0049791** Report Period Beginning: **7/1/10** Ending: **6/30/11**

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	233,514	16,423	7,449	257,386		257,386		257,386		1
2	Food Purchase		194,668		194,668		194,668	(10,791)	183,877		2
3	Housekeeping	185,716	37,846		223,562		223,562		223,562		3
4	Laundry	53,620	12,974		66,594		66,594		66,594		4
5	Heat and Other Utilities			156,015	156,015		156,015		156,015		5
6	Maintenance	29,401	10,762	237,595	277,758		277,758	(72,051)	205,707		6
7	Other (specify):* Garbage Collection			15,856	15,856		15,856		15,856		7
8	TOTAL General Services	502,251	272,673	416,915	1,191,839		1,191,839	(82,842)	1,108,997		8
	B. Health Care and Programs										
9	Medical Director			9,688	9,688		9,688		9,688		9
10	Nursing and Medical Records	2,105,354	201,428	13,108	2,319,890		2,319,890	25,706	2,345,596		10
10a	Therapy	61,358	4,625	303,031	369,014		369,014	38,825	407,839		10a
11	Activities	47,763	2,979	2,350	53,092		53,092		53,092		11
12	Social Services	53,305		2,300	55,605		55,605		55,605		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,267,780	209,032	330,477	2,807,289		2,807,289	64,531	2,871,820		16
	C. General Administration										
17	Administrative	84,683		138,000	222,683		222,683	(138,000)	84,683		17
18	Directors Fees										18
19	Professional Services			161,321	161,321		161,321	2,492	163,813		19
20	Dues, Fees, Subscriptions & Promotions			21,757	21,757	920	22,677	(5,895)	16,782		20
21	Clerical & General Office Expenses	163,941	20,027	16,918	200,886		200,886	(29,712)	171,174		21
22	Employee Benefits & Payroll Taxes			389,574	389,574		389,574	13,978	403,552		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,561	1,561	(920)	641	2,632	3,273		24
25	Other Admin. Staff Transportation			3,944	3,944		3,944	2,450	6,394		25
26	Insurance-Prop.Liab.Malpractice			39,086	39,086		39,086	1,088	40,174		26
27	Other (specify):*										27
28	TOTAL General Administration	248,624	20,027	772,161	1,040,812		1,040,812	(150,967)	889,845		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,018,655	501,732	1,519,553	5,039,940		5,039,940	(169,278)	4,870,662		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 GALESBURG** #0049791 Report Period Beginning: 7/1/10 Ending: 6/30/11

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation							1,572	1,572			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			67,708	67,708		67,708	(59,262)	8,446			32
33	Real Estate Taxes			186,857	186,857		186,857		186,857			33
34	Rent-Facility & Grounds			250,300	250,300		250,300		250,300			34
35	Rent-Equipment & Vehicles			27,979	27,979		27,979		27,979			35
36	Other (specify):*											36
37	TOTAL Ownership			532,844	532,844		532,844	(57,690)	475,154			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		139,532	21,842	161,374		161,374		161,374			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			98,550	98,550		98,550		98,550			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		139,532	120,392	259,924		259,924		259,924			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,018,655	641,264	2,172,789	5,832,708		5,832,708	(226,968)	5,605,740			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

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(9,248)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(6,497)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,279)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(264)	2		13
14	Non-Care Related Interest	(67,708)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				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	(1,457)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,297)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(642)	20		28
29	Other-Attach Schedule	(70,391)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (159,783)		\$	30

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)	(67,185)	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (67,185)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (226,968)		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					44
45	Other-Attach Schedule		X		45
46	Other-Attach Schedule		X		46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

ROSEWOOD CARE CENTER GALESBURG

ID# 0049791

Report Period Beginning: 7/1/10

Ending: 6/30/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Eliminate Marketing Salary	\$ (65,600)	21	1
2	Eliminate Marketing Mileage	(1,718)	25	2
3	Eliminate Lobbying & PAC Dues	(4,068)	20	3
4	Record IDPH License Fee	995	20	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(70,391)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ROSEWOOD CARE CENTER GALESBURG

0049791

Report Period Beginning:

7/1/10

Ending:

6/30/11

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	(10,791)	0	0	0	0	0	0	0	0	0	0	(10,791)	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	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	(72,051)	0	0	0	0	0	0	0	0	(72,051)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(10,791)	0	(72,051)	0	0	0	0	0	0	0	0	(82,842)	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	25,706	0	0	0	0	0	0	0	0	0	25,706	10
10a	Therapy	0	38,825	0	0	0	0	0	0	0	0	0	38,825	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	CNA 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	64,531	0	0	0	0	0	0	0	0	0	64,531	16
	C. General Administration													
17	Administrative	0	(138,000)	0	0	0	0	0	0	0	0	0	(138,000)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,457)	234	3,715	0	0	0	0	0	0	0	0	2,492	19
20	Fees, Subscriptions & Promotions	(6,012)	40	77	0	0	0	0	0	0	0	0	(5,895)	20
21	Clerical & General Office Expenses	(65,600)	35,493	395	0	0	0	0	0	0	0	0	(29,712)	21
22	Employee Benefits & Payroll Taxes	0	11,728	2,250	0	0	0	0	0	0	0	0	13,978	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,499	1,133	0	0	0	0	0	0	0	0	2,632	24
25	Other Admin. Staff Transportation	(1,718)	2,004	2,164	0	0	0	0	0	0	0	0	2,450	25
26	Insurance-Prop.Liab.Malpractice	0	325	763	0	0	0	0	0	0	0	0	1,088	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(74,787)	(86,677)	10,497	0	0	0	0	0	0	0	0	(150,967)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(85,578)	(22,146)	(61,554)	0	0	0	0	0	0	0	0	(169,278)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ROSEWOOD CARE CENTER GALESBURG# 0049791

Report Period Beginning:

7/1/10

Ending:

6/30/11

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	0	1,572	0	0	0	0	0	0	0	0	1,572	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(74,205)	0	14,943	0	0	0	0	0	0	0	0	(59,262)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	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	(74,205)	0	16,515	0	0	0	0	0	0	0	0	(57,690)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(159,783)	(22,146)	(45,039)	0	0	0	0	0	0	0	0	(226,968)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Bravo Services, L.L.C.	100	Bravo Care of Alton, Inc.	Alton, IL	Bravo Care of Wood River, Inc.	Wood River, IL	Supportive Living Facility
		Bravo Care of East Peoria, Inc.	East Peoria, IL	Bravo Nursing Home Services, Inc.	St. Louis, MO	Management Co.
		Bravo Care of Edwardsville, Inc.	Edwardsville, IL	Bravo Holding Company, Inc.	St. Louis, MO	Holding Co.
		Bravo Care of Elgin, Inc.	Elgin, IL			
		Bravo Care of Inverness, Inc.	Inverness, IL			
		Bravo Care of Joliet, Inc.	Joliet, IL			
		Bravo Care of Moline, Inc.	Moline, IL			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	10 See Schedule VIII	\$	Bravo Nursing Home Services, Inc.	100.00%	\$ 25,706	\$	25,706	1
2	V	10a See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	5,763		5,763	2
3	V	19 See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	234		234	3
4	V	20 See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	40		40	4
5	V	21 See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	35,493		35,493	5
6	V	22 See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	11,728		11,728	6
7	V	24 See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	1,499		1,499	7
8	V	25 See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	2,004		2,004	8
9	V	26 See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	325		325	9
10	V	17 Management Fees	138,000	Bravo Nursing Home Services, Inc.	100.00%			(138,000)	10
11	V								11
12	V								12
13	V	10a Therapy	57,932	Bravo Therapy Services, Inc.		90,994		33,062	13
14	Total		\$ 195,932			\$ 173,786	\$ *	(22,146)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	6 Repairs & Maintenance	\$ 96,904	Senior Living Services, Inc.		\$ 24,853	\$ (72,051)
16	V	21 Clerical & Office Expenses		Senior Living Services, Inc.		395	395
17	V	22 Payroll Taxes & Emp Ben.		Senior Living Services, Inc.		2,250	2,250
18	V	24 Travel & Seminar		Senior Living Services, Inc.		1,133	1,133
19	V	25 Other Admin Staff Transportation		Senior Living Services, Inc.		2,164	2,164
20	V	26 Insurance		Senior Living Services, Inc.		514	514
21	V	30 Depreciation		Senior Living Services, Inc.		1,572	1,572
22	V						
23	V						
24	V						
25	V						
26	V	19 Professional Services		Bravo Holding Company		3,715	3,715
27	V	20 Dues & Subscriptions		Bravo Holding Company		77	77
28	V	26 Insurance		Bravo Holding Company		249	249
29	V	32 Interest		Bravo Holding Company		14,943	14,943
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 96,904			\$ 51,865	\$ * (45,039)

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Bravo Care of Northbrook, Inc.	Northbrook, IL	Bravo Therapy			1
2			Bravo Care of Peoria, Inc.	Peoria, IL	Services, Inc.	St. Louis, MO	Therapy Co.	2
3			Bravo Care of Rockford, Inc.	Rockford, IL	Senior Living		Building Services	3
4			Bravo Care of St. Charles, Inc.	St. Charles, IL	Services, Inc.	St. Louis, MO	Company	4
5			Bravo Care of St. Louis, Inc.	St. Louis, MO	Bravo Team		Human Resources	5
6					Health, Inc.	St. Louis, MO	Company	6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number ROSEWOOD CARE CENTER GALESBURG # 0049791 Report Period Beginning: 7/1/10 Ending: 6/30/11

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	Michael Brady	President, Bravo	Administrative	0.00	159,385	3.1	5.16	Salary	\$ 8,672	21, 8	1
2		N.H. Services, Inc.									2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 8,672		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 GALESBURG

0049791

Report Period Beginning:

7/1/10

Ending: 6/30/11

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

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Bravo Nursing Home Services
 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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	Nursing & Medical Records	Total Cost	15	\$ 498,142	\$ 498,142	5,530,661	\$ 25,706	1
2	10a	Therapy	Total Cost	15	111,686	111,686	5,530,661	5,763	2
3	19	Professional Services	Total Cost	15	4,531		5,530,661	234	3
4	20	Dues and Subscriptions	Total Cost	15	777		5,530,661	40	4
5	21	Salaries-Other	Total Cost	15	674,650	674,650	5,530,661	34,814	5
6	21	Taxes, Licenses & Office Supplies	Total Cost	15	2,803		5,530,661	145	6
7	21	Telephone	Total Cost	15	10,343		5,530,661	534	7
8	22	Payroll Taxes	Total Cost	15	93,441		5,530,661	4,822	8
9	22	Employee Benefits	Total Cost	15	133,835		5,530,661	6,906	9
10	24	Travel & Seminar	Total Cost	15	29,046		5,530,661	1,499	10
11	25	Administrative Transportation	Total Cost	15	38,835		5,530,661	2,004	11
12	26	Insurance	Total Cost	15	6,296		5,530,661	325	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,604,385	\$ 1,284,478		\$ 82,792	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROSEWOOD CARE CENTER GALESBURG # 0049791 Report Period Beginning: 7/1/10 Ending: 6/30/11

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										
										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					\$	\$			\$	1									
2										2									
3										3									
4										4									
5										5									
Working Capital																			
6	Related Party Allocation-Bravo Holding Co.	Revolving Line of Credit		8/1/09			12/31/14	5.0000	14,943	6									
7										7									
8	Less: Interest Income Offset								(6,497)	8									
9	TOTAL Facility Related				\$	\$			\$ 8,446	9									
B. Non-Facility Related*																			
10										10									
11										11									
12										12									
13										13									
14	TOTAL Non-Facility Related				\$	\$			\$	14									
15	TOTALS (line 9+line14)				\$	\$			\$ 8,446	15									

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

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 2010 report.		\$	193,883		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.)		\$	190,901		2
3. Under or (over) accrual (line 2 minus line 1).		\$	(2,982)		3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	189,839		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.		\$	186,857		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2006	<u>142,726</u>		8	
	2007	<u>183,524</u>		9	
	2008	<u>187,966</u>		10	
	2009	<u>191,963</u>		11	
	2010	<u>189,839</u>		12	
2009 Payment (\$95,982) + 2010 Payment (\$94,919)					
Accrual = Balance of 2010 tax bill (\$94,919) + 1/2 estimated 2011 tax bill (\$94,920)					
FOR BHF USE ONLY					
	13	FROM R. E. TAX STATEMENT FOR 2010	\$		13
	14	PLUS APPEAL COST FROM LINE 5	\$		14
	15	LESS REFUND FROM LINE 6	\$		15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

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

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ROSEWOOD CARE CENTER GALESBURG COUNTY Knox

FACILITY IDPH LICENSE NUMBER 0049791

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 2010 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 2010.

	(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>99-04-251-012</u>	<u>Rosewood Sub Lots 2 & 3</u>	\$ <u>189,838.52</u>	\$ <u>189,838.52</u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
TOTALS			\$ <u><u>189,838.52</u></u>	\$ <u><u>189,838.52</u></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 and 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 original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation*. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,331 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

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, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable). None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

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:

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a numbered column (1-3). Row 1: Section N/A, Row 2: (blank), Row 3: TOTALS

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **ROSEWOOD CARE CENTER GALESBURG**

0049791

Report Period Beginning:

7/1/10

Ending:

6/30/11

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

*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 and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	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	Building Improvements made by Lessor 5/1/08-6/30/11		\$			\$	\$	37
38	Seal and Stripe Parking Lot	2008	6,245					38
39	Heat Pumps	2009	4,218					39
40	Shower Improvements	2008	10,336					40
41	Seal and Stripe Parking Lot	2010	6,975					41
42	Generator	2010	4,888					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)		\$ 32,662	\$		\$	\$	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 Costs-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	\$ Section Not Applicable	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$	\$	\$	\$		\$	75

D. Vehicle Costs. (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	Senior Living Services	Various	Various	\$ 8,269	\$	\$ 1,572	\$ 1,572	4	\$ 5,944	76
77										77
78										78
79										79
80	TOTALS			\$ 8,269	\$	\$ 1,572	\$ 1,572		\$ 5,944	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)	\$ 40,931	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 1,572	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,572	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,944	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: Galesburg Real Esate, Inc.

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 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1987</u>	<u>120</u>	<u>5/1/08</u>	\$ <u>250,300</u>	<u>4</u>	<u>Unlimited</u>	3
4	Additions	<u>1998</u>	<u>60</u>	<u>5/1/08</u>				4
5								5
6								6
7	TOTAL		<u>180</u>		\$ <u>250,300</u>			7

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 N/A. None
N/A

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: \$ Not Specified 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	<u>Section Not Applicable</u>		\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

10. Effective dates of current rental agreement:

Beginning 5/1/08
Ending 6/30/12

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	<u>6/30/2012</u>	\$ <u>1,077,600</u>
13.	_____	\$ _____
14.	_____	\$ _____

* 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 CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></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 CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

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

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

- (e) The total amount of Drop-out and Completed Costs for your own CNAs 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 CNAs.
- 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	10a, 8	hrs	\$	6,993	\$ 125,811	\$	6,993	\$ 125,811	1
2	Licensed Speech and Language Development Therapist	10a, 8	hrs		988	31,212		988	31,212	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 8	hrs		9,595	179,071	4,625	9,595	183,696	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 2	# of prescripts				139,532		139,532	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Lab,X-Ray,Enterals</u>	39, 3				21,842			21,842	12
13	Other (specify):									13
14	TOTAL			\$	17,576	\$ 357,936	\$ 144,157	17,576	\$ 502,093	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 CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **6/30/11** (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	\$ 95,069	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>50,000</u>)	430,992		3
4	Supply Inventory (priced at <u>Cost</u>)	3,223		4
5	Short-Term Investments			5
6	Prepaid Insurance	24,152		6
7	Other Prepaid Expenses	447,110		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,000,546	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Deposits</u>	2,000		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,000	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,002,546	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 123,144	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	240,900		30
31	Accrued Taxes Payable (excluding real estate taxes)	21,105		31
32	Accrued Real Estate Taxes(Sch.IX-B)	189,839		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	(26,818)		35
Other Current Liabilities(specify):				
36	<u>Accrued Expenses</u>	17,856		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 566,026	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	1,442,280		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)	\$ 1,442,280	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,008,306	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,005,760)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,002,546	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (832,677)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (832,677)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(173,083)	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)	\$ (173,083)	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)	\$ (1,005,760)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROSEWOOD CARE CENTER GALESBURG

0049791

Report Period Beginning: 7/1/10

Ending:

6/30/11

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	\$ 5,699,422	1
2	Discounts and Allowances for all Levels	(860,163)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,839,259	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	773,710	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 773,710	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,700	13
14	Non-Patient Meals	9,248	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 11,948	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	6,497	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,497	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	114	28
28a	Vendor Discount	1,279	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,393	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,632,807	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,191,839	31
32	Health Care	2,807,289	32
33	General Administration	1,040,812	33
B. Capital Expense			
34	Ownership	532,844	34
C. Ancillary Expense			
35	Special Cost Centers	161,374	35
36	Provider Participation Fee	98,550	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,832,708	40
41	Income before Income Taxes (line 30 minus line 40)**	(199,901)	41
42	Income Taxes	(26,818)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (173,083)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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 GALESBURG

0049791

Report Period Beginning:

7/1/10

Ending:

6/30/11

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,947	2,077	\$ 60,424	\$ 29.09	1
2	Assistant Director of Nursing	2,010	2,144	56,648	26.42	2
3	Registered Nurses	10,363	11,055	278,041	25.15	3
4	Licensed Practical Nurses	35,499	37,867	688,654	18.19	4
5	CNAs & Orderlies	88,360	94,256	958,357	10.17	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,753	4,003	61,358	15.33	8
9	Activity Director					9
10	Activity Assistants	4,814	5,135	47,763	9.30	10
11	Social Service Workers	4,170	4,448	53,305	11.98	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,901	23,362	233,514	10.00	15
16	Dishwashers					16
17	Maintenance Workers	2,158	2,302	29,401	12.77	17
18	Housekeepers	18,698	19,946	185,716	9.31	18
19	Laundry	5,618	5,992	53,620	8.95	19
20	Administrator	1,988	2,121	84,683	39.93	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,271	13,089	163,941	12.53	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,661	4,972	63,230	12.72	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	218,211	232,769	\$ 3,018,655 *	\$ 12.97	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	Contract	\$ 7,449	1,3	35
36	Medical Director	Contract	9,688	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	8,065	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Contract	2,350	11,3	44
45	Social Service Consultant	Contract	2,300	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 29,852		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	32	\$ 1,260	10-3	50
51	Licensed Practical Nurses	140	3,483	10-3	51
52	Certified Nurse Assistants/Aides	17	300	10-3	52
53	TOTAL (lines 50 - 52)	189	\$ 5,043		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
Jeff Howd	Administrator	0	\$ 84,683	Workers' Compensation Insurance	\$ 71,700	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	39,825	Advertising: Employee Recruitment	2,910	
				FICA Taxes	225,043	Health Care Worker Background Check	2,441	
				Employee Health Insurance	47,819	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Misc. Dues & Subscriptions	1,084	
				Employee Physicals	432	Promotional Advertising	2,939	
				Employee Uniforms	1,328	Rosewood License Fee	3,000	
				Employee Relations	3,372	Related Party Allocaitons	117	
				Related Party Allocations	13,978	IHCA Dues	6,235	
				Employee Drug Tests	55	Less: Public Relations Expense (
						Non-allowable advertising	(2,297)	
						Yellow page advertising	(642)	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 84,683	TOTAL (agree to Schedule V, line 22, col.8)	\$ 403,552	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 16,782	
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Bravo Nursing Home Services			\$ 138,000	Section Not Applicable		\$	Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 138,000				Related Party Allocations	2,632
(Attach a copy of any management service agreement)								
C. Professional Services							Seminar Expense	641
Vendor/Payee	Type		Amount					
C.J. Schlosser & Company	Accountant/Consultant		\$ 5,700				Entertainment Expense (
Daniel Maher	Collections & Out of Period		1,457				(agree to Sch. V,	
Daniel Maher	Allowable Legal Fees		510				line 24, col. 8)	\$ 3,273
Midwest Administrative Services	Administrative/Bookkeeping		152,799					
Registered Mail	Registered Mail Fees		51					
Old Republic Surety Group	Surety Bond		100					
Claims Admin Services	Allowable Legal Fees		467					
Victoria Spevak	Workers Comp settlement		100					
Kelly,Olson,Michod,DeHaan&Richt	Allowable Legal Fees		137					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 161,321	TOTAL		\$		
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications
 SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
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

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. IHCA \$6,235
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (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. \$ 50,499 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 during this cost report period. \$ 98,550
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, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (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. \$ 9,248
- (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? No
Firm Name: N/A
- (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 \$5,000, 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

Bravo Care of Galesburg, Inc.
Attachment to Schedule VII A
6/30/2011

Name	City	Type of Business
Related Nursing Homes:		
Bravo Care of Alton, Inc.	Alton, IL	Nursing Home
Bravo Care of East Peoria Inc.	East Peoria, IL	Nursing Home
Bravo Care of Edwardsville, Inc.	Edwardsville, IL	Nursing Home
Bravo Care of Elgin, Inc.	Elgin, IL	Nursing Home
Bravo Care of Inverness, Inc.	Inverness, IL	Nursing Home
Bravo Care of Joliet, Inc.	Joliet, IL	Nursing Home
Bravo Care of Moline, Inc.	Moline, IL	Nursing Home
Bravo Care of Northbrook, Inc.	Northbrook, IL	Nursing Home
Bravo Care of Peoria, Inc.	Peoria, IL	Nursing Home
Bravo Care of Rockford, Inc.	Rockford, IL	Nursing Home
Bravo Care of St. Charles, Inc.	St. Charles, IL	Nursing Home
Bravo Care of St. Louis, Inc.	St. Louis, MO	Nursing Home
Other Related Business Entities:		
Bravo Care of Wood River, Inc.	Wood River, IL	Supportive Living Facility
Bravo Nursing Home Services, Inc.	St. Louis, Mo	Management Co.
Bravo Holding Company, Inc.	St. Louis, Mo	Holding Co.
Bravo Therapy Services, Inc.	St. Louis, Mo	Therapy Co.
Bravo Senior Living Services, Inc.	St. Louis, Mo	Building Services Co.
Bravo Team Health, Inc.	St. Louis, Mo	Human Resources Co.