

		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><b>I. IDPH License ID Number:</b> <u>0049312</u></p> <p><b>Facility Name:</b> <u>ROSEWOOD CARE CENTER OF PEORIA</u></p> <p><b>Address:</b> <u>1500 West Northmoor Road</u> <u>Peoria</u> <u>61614</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Peoria</u></p> <p><b>Telephone Number:</b> <u>(309)691-2200</u> <b>Fax #</b> <u>(309)691-1548</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>12/1/07</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT  <input type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust            IRS Exemption Code _____         </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input checked="" type="checkbox"/> Corporation  <input type="checkbox"/> "Sub-S" Corp.  <input type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____         </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____         </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Cindy A. Tefteller</u> <b>Telephone Number:</b> <u>(618)465-7717</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/2010</u> to <u>6/30/2011</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;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td style="width:20%; padding: 5px;">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 &amp; Address) <u>C.J. Schlosser &amp; Company, L.L.C.</u> <u>233 E. Center Drive, Alton, IL 62002</u> (Telephone) <u>(618)465-7717</u> Fax # <u>(618)465-7710</u></td> </tr> </table> <p align="right"> <b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>        201 S. Grand Avenue East        Springfield, IL 62763-0001 <span style="float: right;">Phone # (217) 782-1630</span> </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 &amp; Company, L.L.C.</u> <u>233 E. 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 type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
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 &amp; Company, L.L.C.</u> <u>233 E. Center Drive, Alton, IL 62002</u> (Telephone) <u>(618)465-7717</u> Fax # <u>(618)465-7710</u>							

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROSEWOOD CARE CENTER OF PEORIA

# 0049312 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

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	120	Skilled (SNF)	120	43,800	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	120	TOTALS	120	43,800	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 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF			8,762	8,762		8
9	SNF/PED						9
10	ICF	10,101	12,929		23,030		10
11	ICF/DD						11
12	SC						12
13	DD 16 OR LESS						13
14	TOTALS	10,101	12,929	8,762	31,792		14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.58%

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)  
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 12/1/07

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 12/1/07 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 52 and days of care provided 8,762

Medicare 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.

Facility Name & ID Number **ROSEWOOD CARE CENTER OF PEORIA** # **0049312** Report Period Beginning: **7/1/2010** Ending: **6/30/2011**

**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
	<b>A. General Services</b>										
1	Dietary	217,872	25,018	7,253	250,143		250,143		250,143		1
2	Food Purchase		188,618		188,618		188,618	(8,886)	179,732		2
3	Housekeeping	173,179	35,632		208,811		208,811		208,811		3
4	Laundry	34,323	14,399		48,722		48,722		48,722		4
5	Heat and Other Utilities			115,888	115,888		115,888		115,888		5
6	Maintenance	7,460	10,839	179,440	197,739		197,739	(42,627)	155,112		6
7	Other (specify):* <b>Garbage Collection</b>			10,332	10,332		10,332		10,332		7
8	<b>TOTAL General Services</b>	432,834	274,506	312,913	1,020,253		1,020,253	(51,513)	968,740		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	1,963,791	200,280	24,015	2,188,086		2,188,086	34,169	2,222,255		10
10a	Therapy	90,184	7,289	1,018,124	1,115,597		1,115,597	(48,215)	1,067,382		10a
11	Activities	64,281	4,311	2,400	70,992		70,992		70,992		11
12	Social Services	45,307	100	2,400	47,807		47,807		47,807		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,163,563	211,980	1,064,939	3,440,482		3,440,482	(14,046)	3,426,436		16
	<b>C. General Administration</b>										
17	Administrative	64,724		138,000	202,724		202,724	(138,000)	64,724		17
18	Directors Fees										18
19	Professional Services			300,090	300,090		300,090	(958)	299,132		19
20	Dues, Fees, Subscriptions & Promotions			24,817	24,817	1,200	26,017	(3,447)	22,570		20
21	Clerical & General Office Expenses	148,158	26,462	15,856	190,476		190,476	(20,108)	170,368		21
22	Employee Benefits & Payroll Taxes			408,679	408,679		408,679	18,465	427,144		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,694	1,694	(1,200)	494	3,441	3,935		24
25	Other Admin. Staff Transportation			10,055	10,055		10,055	(3,271)	6,784		25
26	Insurance-Prop.Liab.Malpractice			39,676	39,676		39,676	1,420	41,096		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	212,882	26,462	938,867	1,178,211		1,178,211	(142,458)	1,035,753		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,809,279	512,948	2,316,719	5,638,946		5,638,946	(208,017)	5,430,929		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.

**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							2,011	2,011			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							14,063	14,063			32
33	Real Estate Taxes			98,095	98,095		98,095		98,095			33
34	Rent-Facility & Grounds			1,362,039	1,362,039		1,362,039		1,362,039			34
35	Rent-Equipment & Vehicles			24,783	24,783		24,783		24,783			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,484,917	1,484,917		1,484,917	16,074	1,500,991			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		325,243	48,521	373,764		373,764		373,764			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		325,243	114,221	439,464		439,464		439,464			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,809,279	838,191	3,915,857	7,563,327		7,563,327	(191,943)	7,371,384			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	(7,426)	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	(5,800)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,080)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(380)	2		13
14	Non-Care Related Interest				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	(15)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,208)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,486)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(401)	20		28
29	Other-Attach Schedule	(78,192)	Var.		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (100,988)		\$	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)	(90,955)	Var.	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (90,955)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (191,943)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS  
ROSEWOOD CARE CENTER OF PEORIA

ID# 0049312

Report Period Beginning: 7/1/2010

Ending: 6/30/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Eliminate Marketing Salary	\$ (67,775)	21	1
2	Eliminate Marketing Mileage	(8,701)	25	2
3	Eliminate Lobbying & PAC Dues	(2,711)	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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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	<b>Total</b>	(78,192)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number ROSEWOOD CARE CENTER OF PEORIA

# 0049312

Report Period Beginning:

7/1/2010

Ending:

6/30/2011

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(8,886)	0	0	0	0	0	0	0	0	0	0	(8,886)	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	(42,627)	0	0	0	0	0	0	0	0	(42,627)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(8,886)</b>	<b>0</b>	<b>(42,627)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(51,513)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	34,169	0	0	0	0	0	0	0	0	0	34,169	10
10a	Therapy	0	(48,215)	0	0	0	0	0	0	0	0	0	(48,215)	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>(14,046)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(14,046)</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(6,208)	311	4,939	0	0	0	0	0	0	0	0	(958)	19
20	Fees, Subscriptions & Promotions	(3,603)	53	103	0	0	0	0	0	0	0	0	(3,447)	20
21	Clerical & General Office Expenses	(67,790)	47,178	504	0	0	0	0	0	0	0	0	(20,108)	21
22	Employee Benefits & Payroll Taxes	0	15,589	2,876	0	0	0	0	0	0	0	0	18,465	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,992	1,449	0	0	0	0	0	0	0	0	3,441	24
25	Other Admin. Staff Transportation	(8,701)	2,664	2,766	0	0	0	0	0	0	0	0	(3,271)	25
26	Insurance-Prop.Liab.Malpractice	0	432	988	0	0	0	0	0	0	0	0	1,420	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(86,302)</b>	<b>(69,781)</b>	<b>13,625</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(142,458)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(95,188)</b>	<b>(83,827)</b>	<b>(29,002)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(208,017)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number ROSEWOOD CARE CENTER OF PEORIA# 0049312

Report Period Beginning:

7/1/2010

Ending:

6/30/2011

## 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)	
	<b>D. Ownership</b>													
30	Depreciation	0	0	2,011	0	0	0	0	0	0	0	0	2,011	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,800)	0	19,863	0	0	0	0	0	0	0	0	14,063	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	<b>TOTAL Ownership</b>	<b>(5,800)</b>	<b>0</b>	<b>21,874</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16,074</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(100,988)	(83,827)	(7,128)	0	0	0	0	0	0	0	0	(191,943)	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 Galesburg, Inc.	Galesburg, IL			
		Bravo Care of Inverness, Inc.	Inverness, IL			
		Bravo Care of Joliet, Inc.	Joliet, 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:	
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	10 See Schedule VIII	\$	Bravo Nursing Home Services, Inc.	100.00%	\$ 34,169	\$ 34,169	1
2	V	10a See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	7,661	7,661	2
3	V	19 See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	311	311	3
4	V	20 See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	53	53	4
5	V	21 See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	47,178	47,178	5
6	V	22 See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	15,589	15,589	6
7	V	24 See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	1,992	1,992	7
8	V	25 See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	2,664	2,664	8
9	V	26 See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	432	432	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	299,238	Bravo Therapy Services, Inc.		243,362	(55,876)	13
14	Total		\$ 437,238			\$ 353,411	\$ * (83,827)	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	\$ 122,237	Senior Living Services, Inc.		\$ 79,610	\$ (42,627)
16	V	21 Clerical & Office Expenses		Senior Living Services, Inc.		504	504
17	V	22 Payroll Taxes & Emp Ben.		Senior Living Services, Inc.		2,876	2,876
18	V	24 Travel & Seminar		Senior Living Services, Inc.		1,449	1,449
19	V	25 Other Admin Staff Transportation		Senior Living Services, Inc.		2,766	2,766
20	V	26 Insurance		Senior Living Services, Inc.		657	657
21	V	30 Depreciation		Senior Living Services, Inc.		2,011	2,011
22	V						
23	V						
24	V						
25	V						
26	V	19 Professional Services		Bravo Holding Company		4,939	4,939
27	V	20 Dues & Subscriptions		Bravo Holding Company		103	103
28	V	26 Insurance		Bravo Holding Company		331	331
29	V	32 Interest		Bravo Holding Company		19,863	19,863
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 122,237			\$ 115,109	\$ * (7,128)

\* 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 Moline, Inc.	Moline, IL	Bravo Therapy			1
2			Bravo Care of Northbrook, Inc.	Northbrook, 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 OF PEORIA # 0049312 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

## 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	156,529	4.12	6.86	Salary	\$ 11,528	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	\$ 11,528		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROSEWOOD CARE CENTER OF PEORIA

# 0049312

Report Period Beginning:

7/1/2010

Ending: 5/30/2011

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  
 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	7,351,647	\$ 34,169	1
2	10a	Therapy	Total Cost	15	111,686	111,686	7,351,647	7,661	2
3	19	Professional Services	Total Cost	15	4,531		7,351,647	311	3
4	20	Dues & Subscriptions	Total Cost	15	777		7,351,647	53	4
5	21	Salaries - Other	Total Cost	15	674,650	674,650	7,351,647	46,277	5
6	21	Taxes, Licenses, & Office Sup	Total Cost	15	2,803		7,351,647	192	6
7	21	Telephone	Total Cost	15	10,343		7,351,647	709	7
8	22	Payroll Taxes	Total Cost	15	93,441		7,351,647	6,409	8
9	22	Employee Benefits	Total Cost	15	133,835		7,351,647	9,180	9
10	24	Travel & Seminar	Total Cost	15	29,046		7,351,647	1,992	10
11	25	Administrative Transportation	Total Cost	15	38,835		7,351,647	2,664	11
12	26	Insurance	Total Cost	15	6,296		7,351,647	432	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		\$ 110,049	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

ROSEWOOD CARE CENTER OF PEORIA

# 0049312

Report Period Beginning:

7/1/2010

Ending:

6/30/2011

**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			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1					\$	\$			\$	1									
2										2									
3										3									
4										4									
5										5									
<b>Working Capital</b>																			
6	<b>Conduit Interest Allocated from</b>									6									
7	<b>Bravo Holding - Schedule VII B.</b>		<b>Revolving Line of Credit</b>		<b>8/1/09</b>			<b>12/31/14</b>	<b>5.0000</b>	<b>19,863</b>									
8	<b>Less: Interest Income Offset</b>									<b>(5,800)</b>									
9	<b>TOTAL Facility Related</b>				\$	\$			\$	<b>14,063</b>									
<b>B. Non-Facility Related*</b>																			
10										10									
11										11									
12										12									
13										13									
14	<b>TOTAL Non-Facility Related</b>				\$	\$			\$										
15	<b>TOTALS (line 9+line14)</b>				\$	\$			\$	<b>14,063</b>									

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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>																						
1. Real Estate Tax accrual used on 2010 report.		\$	<b>97,550</b>	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.)		\$	<b>97,247</b>	2																				
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(303)</b>	3																				
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>98,398</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6																				
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>98,095</b>	7																				
Real Estate Tax History:																								
Real Estate Tax Bill for Calendar Year:	2006	<u>83,376</u>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="3" style="text-align: center;"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2010</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">16</td> </tr> </table>		<b>FOR BHF USE ONLY</b>			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
<b>FOR BHF USE ONLY</b>																								
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																					
	2007	<u>85,895</u>	9																					
	2008	<u>91,703</u>	10																					
	2009	<u>96,584</u>	11																					
	2010	<u>97,909</u>	12																					
<b>2009 Payment (\$48,292) + 2010 Payment (\$48,955)</b>																								
<b>Accrual = Remaining balance of 2010 tax bill (\$48,954) + 1/2 estimated 2011 tax bill (\$49,444)</b>																								

**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**



**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 38,500 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.  
 (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, CNA training facilities, etc.)  
 List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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F. 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:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Schedule N/A</u>			\$	1
2					2
3	TOTALS			\$	3

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	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
	<b>Improvement Type**</b>									
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)**

**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	\$ <b>Section Not Applicable</b>	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	<b>TOTALS</b>	\$	\$	\$	\$		\$	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	<b>Senior Living Services</b>	<b>Various</b>	<b>Various</b>	\$ <b>10,572</b>	\$	\$ <b>2,011</b>	\$ <b>2,011</b>	<b>4</b>	\$ <b>7,599</b>	76
77										77
78										78
79										79
80	<b>TOTALS</b>			\$ <b>10,572</b>	\$	\$ <b>2,011</b>	\$ <b>2,011</b>		\$ <b>7,599</b>	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)	\$ <b>185,940</b>	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)	\$ <b>2,011</b>	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ <b>2,011</b>	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ <b>7,599</b>	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	<b>Section Not Applicable</b>	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	<b>TOTALS</b>	\$	\$	\$	91

**G. Construction-in-Progress**

	Description	Cost	
92	<b>Section Not Applicable</b>	\$	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: Peoria Real Estate, 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>1989</u>	<u>120</u>	<u>12/1/07</u>	\$ <u>1,362,039</u>	<u>3</u>	<u>Unlimited</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		120		\$ <u>1,362,039</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: N/A \*

**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 12/1/10

Ending 11/30/11

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ \$ \_\_\_\_\_  
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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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**

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

- (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	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
							Units	Cost								
1	Licensed Occupational Therapist	10a, 8	hrs	\$	24,537	\$	395,964	\$	24,537	\$	395,964					1
2	Licensed Speech and Language Development Therapist	10a, 8	hrs		6,383		133,773		6,383		133,773					2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	10a, 8	hrs		25,846		432,510		25,846		439,799					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								325,243				325,243	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify): <u>Labs, X-Rays, External</u>	39, 3					48,521				48,521					12
13	Other (specify):															13
14	<b>TOTAL</b>			\$	56,766	\$	1,010,768	\$	56,766	\$	1,343,300					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 **6/30/2011**

(last day of reporting year)

**This report must be completed even if financial statements are attached.**

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 146,460	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>80,000</u> )	1,093,500		3
4	Supply Inventory (priced at <u>Cost</u> )	2,770		4
5	Short-Term Investments			5
6	Prepaid Insurance	19,425		6
7	Other Prepaid Expenses	3,434		7
8	Accounts Receivable (owners or related parties)	526,354		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,791,943	\$	10
<b>B. Long-Term Assets</b>				
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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,000	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,793,943	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 218,831	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	195,968		30
31	Accrued Taxes Payable (excluding real estate taxes)	35,982		31
32	Accrued Real Estate Taxes(Sch.IX-B)	98,398		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	112,451		35
<b>Other Current Liabilities(specify):</b>				
36	<u>Accrued Expenses</u>	60,508		36
37	<u>Accrued Rent</u>	54,300		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 776,438	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 776,438	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,017,505	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,793,943	\$	48

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>367,660</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>367,660</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>717,345</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(67,500)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>649,845</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,017,505</b>	<b>24</b> *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number ROSEWOOD CARE CENTER OF PEORIA

# 0049312

Report Period Beginning: 7/1/2010

Ending: 6/30/2011

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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 8,672,966	1
2	Discounts and Allowances for all Levels	(2,902,669)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,770,297	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,603,429	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 2,603,429	8
<b>C. Other Operating Revenue</b>			
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	4,800	13
14	Non-Patient Meals	7,426	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 12,226	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	5,800	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 5,800	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Vendor Discount</u>	1,080	28
28a	<u>Miscellaneous</u>	291	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,371	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 8,393,123	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,020,253	31
32	Health Care	3,440,482	32
33	General Administration	1,178,211	33
<b>B. Capital Expense</b>			
34	Ownership	1,484,917	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	373,764	35
36	Provider Participation Fee	65,700	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,563,327	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	829,796	41
42	<b>Income Taxes</b>	112,451	42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 717,345	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 OF PEORIA**

# **0049312**

Report Period Beginning: **7/1/2010**

Ending:

**6/30/2011**

**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	1,834	1,935	\$ 57,802	\$ 29.87	1
2	Assistant Director of Nursing	2,007	2,117	57,657	27.24	2
3	Registered Nurses	22,293	23,519	609,225	25.90	3
4	Licensed Practical Nurses	16,144	17,033	364,986	21.43	4
5	CNAs & Orderlies	66,703	70,373	789,637	11.22	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,470	4,716	90,184	19.12	8
9	Activity Director					9
10	Activity Assistants	5,024	5,300	64,281	12.13	10
11	Social Service Workers	3,869	4,082	45,307	11.10	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,680	20,763	217,872	10.49	15
16	Dishwashers					16
17	Maintenance Workers	454	479	7,460	15.57	17
18	Housekeepers	16,432	17,336	173,179	9.99	18
19	Laundry	3,804	4,014	34,323	8.55	19
20	Administrator	2,020	2,131	64,724	30.37	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,974	12,633	148,158	11.73	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	5,324	5,617	84,484	15.04	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	182,032	192,048	\$ 2,809,279 *	\$ 14.63	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	\$ 7,253	1,3	35
36	Medical Director	Contract	18,000	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	7,397	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	2,400	11,3	44
45	Social Service Consultant	Contract	2,400	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 37,450		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	8	\$ 315	10-3	50
51	Licensed Practical Nurses	492	16,303	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	500	\$ 16,618		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Timothy Wiley	Administrator	0	\$ 64,724	Workers' Compensation Insurance	\$ 64,326	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	97,132	Advertising: Employee Recruitment	8,936	
				FICA Taxes	207,996	Health Care Worker Background Check	3,759	
				Employee Health Insurance	36,056	(Indicate # of checks performed)		
				Employee Meals		IHCA Dues	4,158	
				Illinois Municipal Retirement Fund (IMRF)*		Misc. Dues/Subscriptions	1,566	
				Employee Relations	1,950	Rosewood License Fee	3,000	
				Employee Uniforms	715	Promotional Advertising	1,887	
				Employee Physicals	368	Related Party Allocation	156	
				Related Party Allocation	18,465			
				Employee Drug Tests	136	Less: Public Relations Expense	( )	
						Non-allowable advertising	(1,486)	
						Yellow page advertising	(401)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		
					\$ 427,144			
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	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)							In-State Travel	
							Related Party Allocation	3,441
							Seminar Expense	494
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 3,935

\* 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 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5-13 Amount of Expense Amortized Per Year								
					6 FY2007	7 FY2008	8 FY2009	9 FY2010	10 FY2011	11 FY2012	12 FY2013	13 FY2014	14 FY2015
1	Schedule Not Applicable		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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 \$4,158
- (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? None
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 55,058 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 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. \$ 65,700  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, 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. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 7,426
- (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