

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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 Drive</u> <u>Galesburg</u> <u>61401</u> Number City Zip Code</p> <p>County: <u>Knox</u></p> <p>Telephone Number: <u>(309)344-5400</u> Fax # _____</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 border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></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>7/1/2011</u> to <u>6/30/12</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"> <tr> <td rowspan="2" style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) _____</td> </tr> <tr> <td></td> <td>(Title) _____</td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) <u>See Accountant's Compilation Report</u></td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Cindy A. Tefteller</u></td> </tr> <tr> <td>(Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 E. Center Drive, Alton, IL 62002</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(618)465-7717</u> Fax # <u>(618)465-7710</u></td> </tr> </table> <p>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) _____	(Date) _____		(Type or Print Name) _____		(Title) _____	Paid Preparer	(Signed) <u>See Accountant's Compilation Report</u>	(Date) _____	(Print Name and Title) <u>Cindy A. Tefteller</u>	(Firm Name & Address) <u>C.J. Schlosser & 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>
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Galesburg

0049791 Report Period Beginning: 7/1/2011 Ending: 6/30/12

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 N/A

	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	65,880	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	65,880	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			3,681	3,681	8
9	SNF/PED					9
10	ICF	22,136	11,260		33,396	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,136	11,260	3,681	37,077	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 56.28%

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 5/1/2008

J. 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 3,681

Medicare Intermediary Pinnacle Business Solutions, Inc.

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/12 Fiscal Year: 6/30/12

* 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:

7/1/2011

Ending:

6/30/12

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	238,651	14,238	7,921	260,810		260,810		260,810		1
2	Food Purchase		204,472		204,472		204,472	(7,079)	197,393		2
3	Housekeeping	199,209	42,985		242,194		242,194		242,194		3
4	Laundry	54,974	14,518		69,492		69,492		69,492		4
5	Heat and Other Utilities			156,722	156,722		156,722		156,722		5
6	Maintenance	30,238	10,793	211,565	252,596		252,596	(66,923)	185,673		6
7	Other (specify):* Waste Disposal			16,773	16,773		16,773		16,773		7
8	TOTAL General Services	523,072	287,006	392,981	1,203,059		1,203,059	(74,002)	1,129,057		8
	B. Health Care and Programs										
9	Medical Director			8,250	8,250		8,250		8,250		9
10	Nursing and Medical Records	2,138,963	174,147	8,286	2,321,396		2,321,396	30,428	2,351,824		10
10a	Therapy	63,061	2,761		65,822		65,822	3,848	69,670		10a
11	Activities	51,885	3,826	2,400	58,111		58,111		58,111		11
12	Social Services	54,970		2,400	57,370		57,370		57,370		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,308,879	180,734	21,336	2,510,949		2,510,949	34,276	2,545,225		16
	C. General Administration										
17	Administrative	86,564		138,000	224,564		224,564	(127,087)	97,477		17
18	Directors Fees										18
19	Professional Services			165,645	165,645		165,645	4,526	170,171		19
20	Dues, Fees, Subscriptions & Promotions			20,326	20,326	4,305	24,631	(9,525)	15,106		20
21	Clerical & General Office Expenses	171,074	20,895	15,757	207,726		207,726	(34,918)	172,808		21
22	Employee Benefits & Payroll Taxes			382,982	382,982		382,982	14,716	397,698		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,471	5,471	(4,305)	1,166	2,746	3,912		24
25	Other Admin. Staff Transportation			3,769	3,769		3,769	1,299	5,068		25
26	Insurance-Prop.Liab.Malpractice			41,490	41,490		41,490	667	42,157		26
27	Other (specify):*										27
28	TOTAL General Administration	257,638	20,895	773,440	1,051,973		1,051,973	(147,576)	904,397		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,089,589	488,635	1,187,757	4,765,981		4,765,981	(187,302)	4,578,679		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 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	
	D. Ownership											
30	Depreciation							823	823			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			111,192	111,192		111,192	(73,190)	38,002			32
33	Real Estate Taxes			114,095	114,095		114,095		114,095			33
34	Rent-Facility & Grounds			833,276	833,276		833,276		833,276			34
35	Rent-Equipment & Vehicles			30,178	30,178		30,178		30,178			35
36	Other (specify):*											36
37	TOTAL Ownership			1,088,741	1,088,741		1,088,741	(72,367)	1,016,374			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		128,723	347,731	476,454		476,454		476,454			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			299,209	299,209		299,209		299,209			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		128,723	646,940	775,663		775,663		775,663			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,089,589	617,358	2,923,438	6,630,385		6,630,385	(259,669)	6,370,716			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Galesburg

0049791

Report Period Beginning: 7/1/2011

Ending: 6/30/12

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	(5,822)	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	(7,203)	32		10
11	Discounts, Allowances, Rebates & Refunds	(950)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(307)	2		13
14	Non-Care Related Interest	(111,192)	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	(333)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,818)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(537)	20		28
29	Other-Attach Schedule See Attached	(82,148)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (211,310)		\$	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)	(48,359)	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (48,359)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (259,669)		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: 7/1/2011

Ending: 6/30/12

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Eliminate Marketing Salary	\$ (67,340)	21	1
2	Eliminate Marketing Payroll Taxes	(5,152)	22	2
3	Eliminate Marketing Mileage	(3,376)	25	3
4	Eliminate Lobbying & PAC Dues	(4,290)	20	4
5	Eliminate Out of Period IDPH License Fees	(1,990)	20	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
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
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		(82,148)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Center Galesburg# 0049791

Report Period Beginning:

7/1/2011

Ending:

6/30/12

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(7,079)	0	0	0	0	0	0	0	0	0	0	(7,079)	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	(66,923)	0	0	0	0	0	0	0	0	(66,923)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(7,079)	0	(66,923)	0	0	0	0	0	0	0	0	(74,002)	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	30,428	0	0	0	0	0	0	0	0	0	30,428	10
10a	Therapy	0	3,848	0	0	0	0	0	0	0	0	0	3,848	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	34,276	0	0	0	0	0	0	0	0	0	34,276	16
	C. General Administration													
17	Administrative	0	(127,087)	0	0	0	0	0	0	0	0	0	(127,087)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(333)	296	4,563	0	0	0	0	0	0	0	0	4,526	19
20	Fees, Subscriptions & Promotions	(9,635)	15	95	0	0	0	0	0	0	0	0	(9,525)	20
21	Clerical & General Office Expenses	(67,340)	31,933	489	0	0	0	0	0	0	0	0	(34,918)	21
22	Employee Benefits & Payroll Taxes	(5,152)	17,403	2,465	0	0	0	0	0	0	0	0	14,716	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,632	1,114	0	0	0	0	0	0	0	0	2,746	24
25	Other Admin. Staff Transportation	(3,376)	2,425	2,250	0	0	0	0	0	0	0	0	1,299	25
26	Insurance-Prop.Liab.Malpractice	0	0	667	0	0	0	0	0	0	0	0	667	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(85,836)	(73,383)	11,643	0	0	0	0	0	0	0	0	(147,576)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(92,915)	(39,107)	(55,280)	0	0	0	0	0	0	0	0	(187,302)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Center Galesburg# 0049791

Report Period Beginning:

7/1/2011

Ending:

6/30/12

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	823	0	0	0	0	0	0	0	0	823	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(118,395)	0	45,205	0	0	0	0	0	0	0	0	(73,190)	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	(118,395)	0	46,028	0	0	0	0	0	0	0	0	(72,367)	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)	(211,310)	(39,107)	(9,252)	0	0	0	0	0	0	0	0	(259,669)	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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10 See Schedule VIII	\$	Bravo Nursing Home Services, Inc.	100.00%	\$ 30,428	\$ 30,428	1
2	V	10a See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	3,848	3,848	2
3	V	19 See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	296	296	3
4	V	20 See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	15	15	4
5	V	21 See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	31,933	31,933	5
6	V	22 See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	17,403	17,403	6
7	V	24 See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	1,632	1,632	7
8	V	25 See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	2,425	2,425	8
9	V	17 Management Fees	138,000	Bravo Nursing Home Services, Inc.	100.00%	10,913	(127,087)	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 138,000			\$ 98,893	\$ * (39,107)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Galesburg# 0049791Report Period Beginning: 7/1/2011Ending: 6/30/12

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	\$ 91,598	Senior Living Services, Inc.		\$ 24,675	\$ (66,923)
16	V	21 Clerical & Office Expenses		Senior Living Services, Inc.		450	450
17	V	22 Payroll Taxes & Emp Ben.		Senior Living Services, Inc.		2,228	2,228
18	V	24 Travel & Seminar		Senior Living Services, Inc.		1,056	1,056
19	V	25 Other Admin Staff Transportation		Senior Living Services, Inc.		2,200	2,200
20	V	26 Insurance		Senior Living Services, Inc.		450	450
21	V	30 Depreciation		Senior Living Services, Inc.		823	823
22	V						
23	V	19 Professional Services	2,513	Claims Administrative Services, LLC		3,939	1,426
24	V	20 Dues, Fees, & Subscriptions		Claims Administrative Services, LLC		5	5
25	V	21 Clerical & Office Expenses		Claims Administrative Services, LLC		39	39
26	V	22 Payroll Taxes & Emp Ben.		Claims Administrative Services, LLC		237	237
27	V	24 Travel & Seminar		Claims Administrative Services, LLC		58	58
28	V	25 Other Admin Staff Transportation		Claims Administrative Services, LLC		50	50
29	V						
30	V	19 Professional Services		Bravo Holding Company		3,137	3,137
31	V	20 Dues, Fees, & Subscriptions		Bravo Holding Company		90	90
32	V	26 Insurance		Bravo Holding Company		217	217
33	V	32 Interest		Bravo Holding Company		45,205	45,205
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 94,111			\$ 84,859	\$ * (9,252)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Rosewood Care Center Galesburg

0049791

Report Period Beginning:

7/1/2011

Ending:

6/30/12

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	Senior Living		Building Services	1
2			Bravo Care of Peoria, Inc.	Peoria, IL	Services, Inc.	St. Louis, MO	Company	2
3			Bravo Care of Rockford, Inc.	Rockford, IL	Bravo Team		Human Resources	3
4			Bravo Care of St. Charles, Inc.	St. Charles, IL	Health, Inc.	St. Louis, MO	Company	4
5			Bravo Care of St. Louis, Inc.	ST. Louis, MO				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
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Galesburg # 0049791 Report Period Beginning: 7/1/2011 Ending: 6/30/12

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	176,533	3.49	5.82	Salary	\$ 10,913	17,8	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	\$ 10,913		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:

7/1/2011

Ending:

6/30/12

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 Redords	Total Cost	15	\$ 522,626	\$ 522,626	6,291,088	\$ 30,428	1
2	10a	Therapy	Total Cost	15	66,088	66,088	6,291,088	3,848	2
3	19	Professional Services	Total Cost	15	5,077		6,291,088	296	3
4	20	Dues & Subscriptions	Total Cost	15	252		6,291,088	15	4
5	21	Salaries - Other	Total Cost	15	535,914	535,914	6,291,088	31,201	5
6	21	Taxes, Licenses & Office Supplies	Total Cost	15	2,363		6,291,088	138	6
7	21	Telephone	Total Cost	15	10,197		6,291,088	594	7
8	22	Payroll Taxes	Total Cost	15	98,592		6,291,088	5,740	8
9	22	Employee Benefits	Total Cost	15	200,331		6,291,088	11,663	9
10	24	Travel & Seminar	Total Cost	15	28,031		6,291,088	1,632	10
11	25	Administrative Transportation	Total Cost	15	41,648		6,291,088	2,425	11
12	17	Salaries - Officer	Total Cost	15	187,446	187,446	6,291,088	10,913	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				\$ 1,698,565	\$ 1,312,074		\$ 98,893	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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							\$	\$			\$					
2																
3																
4																
5																
	Working Capital															
6	Bravo Holding Co. Cost Allocation			Revolving Line of Credit		8/1/09		2,280,292	12/31/14	5.0000	45,205					
7																
8	Less: Interest Income Offset										(7,203)					
9	TOTAL Facility Related															
	B. Non-Facility Related*															
10																
11																
12																
13																
14	TOTAL Non-Facility Related															
15	TOTALS (line 9+line14)															
							\$	\$		\$						
								2,280,292			38,002					

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.)

Facility Name & ID Number Rosewood Care Center Galesburg# 0049791

Report Period Beginning:

7/1/2011

Ending:

6/30/12

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 2011 report.		\$	<u>189,839</u>	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.)		\$	<u>164,591</u>	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>(25,248)</u>	3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>139,343</u>	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.		\$	<u>114,095</u>	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2007	<u>183,524</u>	8	FOR BHF USE ONLY	
	2008	<u>187,966</u>	9	13	FROM R. E. TAX STATEMENT FOR 2011 \$ 13
	2009	<u>191,963</u>	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2010	<u>189,839</u>	11	15	LESS REFUND FROM LINE 6 \$ 15
	2011	<u>139,343</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
<u>2010 Payment = \$94,919</u>					
<u>2011 Payment = \$69,672</u>					
<u>Accrual = Remaining balance of 2011 tax bill (\$69,671) + 1/2 estimated 2012 tax bill (\$69,672)</u>					

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

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.**

Facility Name & ID Number Rosewood Care Center Galesburg

0049791 Report Period Beginning:

7/1/2011 Ending:

6/30/12

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.
 (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

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:

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Galesburg

0049791

Report Period Beginning:

7/1/2011

Ending:

6/30/12

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		\$	\$		\$	\$	\$
38	2008	6,245					
39	2009	4,218					
40	2008	10,336					
41	2010	6,975					
42	2010	4,888					
43	2011	14,790					
44	2012	6,753					
45							
46							
47							
48							
49							
50							
51							
52							
53							
54							
55							
56							
57							
58							
59							
60							
61							
62							
63							
64							
65							
66							
67							
68							
69							
70	TOTAL (lines 4 thru 69)	\$ 54,205	\$		\$	\$	\$

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	\$ 7,465	\$	\$ 823	\$ 823	4	\$ 5,241	76
77										77
78										78
79										79
80	TOTALS			\$ 7,465	\$	\$ 823	\$ 823		\$ 5,241	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)	\$ 61,670	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)	\$ 823	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 823	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,241	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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Galesburg 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>1987</u>	<u>120</u>	<u>5/1/08</u>	\$ <u>833,276</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>833,276</u>			7

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. /2013 \$ _____

13. /2014 \$ _____

14. /2015 \$ _____

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

* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Galesburg # 0049791 Report Period Beginning: 7/1/2011 Ending: 6/30/12
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	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,8	hrs				2,762		2,762	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 prescrpts				128,723		128,723	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Physical, Occupational, & Speech Therapy Other (specify): <u>Lab,X-Ray,Enterals</u>	39,3				347,731			347,731	13
14	TOTAL			\$		\$ 347,731	\$ 131,485		\$ 479,216	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

Facility Name & ID Number Rosewood Care Center Galesburg# 0049791Report Period Beginning: 7/1/2011

Ending:

6/30/12

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/12

(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	\$ 102,619	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>45,000</u>)	734,509		3
4	Supply Inventory (priced at <u>Cost</u>)	3,605		4
5	Short-Term Investments			5
6	Prepaid Insurance	18,697		6
7	Other Prepaid Expenses	5,483		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 864,913	\$	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)	\$ 866,913	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 184,802	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	268,789		30
31	Accrued Taxes Payable (excluding real estate taxes)	24,100		31
32	Accrued Real Estate Taxes(Sch.IX-B)	139,343		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Expenses</u>	119,051		36
37	<u>Accrued Rent</u>	75,000		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 811,085	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,280,292		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)	\$ 2,280,292	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,091,377	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (2,224,464)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 866,913	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,005,760)	1
2	Restatements (describe):		2
3			3
4	Adjustment to Prior Year Rent Expense after year end	(441,625)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,447,385)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(777,079)	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)	\$ (777,079)	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)	\$ (2,224,464)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,900,387	1
2	Discounts and Allowances for all Levels	(937,198)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,963,189	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	871,091	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 871,091	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	5,822	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)	\$ 8,522	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	7,203	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,203	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See attached schedule</u>	3,301	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,301	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,853,306	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,203,059	31
32	Health Care	2,510,949	32
33	General Administration	1,051,973	33
B. Capital Expense			
34	Ownership	1,088,741	34
C. Ancillary Expense			
35	Special Cost Centers	476,454	35
36	Provider Participation Fee	299,209	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,630,385	40
41	Income before Income Taxes (line 30 minus line 40)**	(777,079)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (777,079)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,289,606	44
45	Private Pay - Net Inpatient Revenue	1,764,811	45
46	Medicare - Net Inpatient Revenue	824,055	46
47	Other-(specify) <u>Managed Care - Net Inpatient Revenue</u>	84,717	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,963,189	49

* 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.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Galesburg

0049791

Report Period Beginning: 7/1/2011

Ending: 6/30/12

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,010	2,160	\$ 64,346	\$ 29.79	1
2	Assistant Director of Nursing	1,936	2,080	55,969	26.91	2
3	Registered Nurses	10,592	11,382	286,479	25.17	3
4	Licensed Practical Nurses	33,638	36,148	662,541	18.33	4
5	CNAs & Orderlies	92,245	99,129	1,001,489	10.10	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,762	4,043	63,061	15.60	8
9	Activity Director					9
10	Activity Assistants	5,170	5,556	51,885	9.34	10
11	Social Service Workers	4,177	4,489	54,970	12.25	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,029	23,673	238,651	10.08	15
16	Dishwashers					16
17	Maintenance Workers	2,170	2,332	30,238	12.97	17
18	Housekeepers	19,410	20,858	199,209	9.55	18
19	Laundry	5,552	5,967	54,974	9.21	19
20	Administrator	1,983	2,131	86,564	40.62	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,498	13,430	171,074	12.74	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	4,664	5,013	68,139	13.59	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	221,836	238,391	\$ 3,089,589 *	\$ 12.96	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	\$ 7,921	1,3	35
36	Medical Director	Contract	8,250	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	8,286	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)		\$ 29,257		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	Section N/A	\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Galesburg

0049791

Report Period Beginning: 7/1/2011

Ending: 6/30/12

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	
Jeff Howd	Administrator	0	\$ 86,564	Workers' Compensation Insurance	\$ 57,134	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	47,871	Advertising: Employee Recruitment	1,718	
				FICA Taxes	225,994	Health Care Worker Background Check	1,766	
				Employee Health Insurance	40,190	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		IHCA Dues	6,013	
				Employee Relations	2,979	Rosewood License Fee	3,000	
				Employee Uniforms	863	Promotional Advertising	3,355	
				Employee Physicals	1,244	Misc. Dues/Subscriptions/Fees	509	
				Related Party Allocations	19,868	Related Party Allocation	110	
				Employee Drug Tests	55	Less: Public Relations Expense (
				Tuition Reimbursement	1,500	Non-allowable advertising	(2,818)	
						Yellow page advertising	(537)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
\$ 86,564				\$ 397,698			\$ 15,106	
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)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
\$ 138,000				\$			\$ 3,912	
C. Professional Services								
Vendor/Payee	Type		Amount					
C.J. Schlosser & Company	Accountant/Consultant		\$ 4,145					
Midwest Administrative Services	Administrative Fees		154,244					
Daniel Maher	Collections & Out of Period		333					
Daniel Maher	Allowable Legal Fees		4,410					
Claims Admin Services	Related Party Legal Fees		2,513					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL			Entertainment Expense (
\$ 165,645				\$			(agree to Sch. V, line 24, col. 8)	

* 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	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

Facility Name & ID Number Rosewood Care Center Galesburg# 0049791Report Period Beginning: 7/1/2011Ending: 6/30/12**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 \$6,013
- (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. \$ 52,718 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. \$ 299,209
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. \$ 5,822
- (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 Center of Galesburg
Attachment to Schedule XII D
Other Revenue
6/30/2012

Description		
28A	Vendor Discount	\$ 950
28B	Miscellaneous Income	81
28C	Vending Income	2,270
		<u>\$ 3,301</u>