		FOR BHF USE					

LL1

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.

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

I. IDPH License ID Number: 0049320

Facility Name: Rosewood Care Ctr St. Charles

Address: 850 Dunham Road (Number) St. Charles (City) 60174 (Zip Code)

County: Kane

Telephone Number: (630)443-6146 **Fax #** (630)443-4461

HFS ID Number:

Date of Initial License for Current Owners: 12/1/07

Type of Ownership:

VOLUNTARY,NON-PROFIT	PROPRIETARY	GOVERNMENTAL
[ ] VOLUNTARY,NON-PROFIT	[X] PROPRIETARY	[ ] GOVERNMENTAL
[ ] Charitable Corp.	[ ] Individual	[ ] State
[ ] Trust	[ ] Partnership	[ ] County
IRS Exemption Code	[X] Corporation	[ ] Other
	[ ] "Sub-S" Corp.	
	[ ] Limited Liability Co.	
	[ ] Trust	
	[ ] Other	

In the event there are further questions about this report, please contact:
Name: Cindy A. Tefteller Telephone Number: (618)465-7717
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2011 to 6/30/2012 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed) See Accountant's Compilation Report	(Date)
	(Print Name and Title)	Cindy A. Tefteller
	(Firm Name & Address)	C.J. Schlosser & Company, L.L.C. 233 E. Center Drive, Alton IL 62002
	(Telephone)	(618)465-7717 Fax # (618)465-7710

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr St. Charles # 0049320 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	109	Skilled (SNF)	109	39,894	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	109	TOTALS	109	39,894	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			5,887	5,887	8
9	SNF/PED					9
10	ICF	10,617	10,461		21,078	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,617	10,461	5,887	26,965	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.59%

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 [X]

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

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 [X] Date 12/1/07 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 41 and days of care provided 5,887

Medicare Intermediary Pinnacle Business Solutions, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] 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 Ctr St. Charles # 0049320 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	210,412	25,405	9,516	245,333		245,333		245,333			1
2	Food Purchase		175,571		175,571		175,571	(2,875)	172,696			2
3	Housekeeping	162,119	31,579		193,698		193,698		193,698			3
4	Laundry	21,454	16,803		38,257		38,257		38,257			4
5	Heat and Other Utilities			169,607	169,607		169,607		169,607			5
6	Maintenance	37,609	15,728	291,100	344,437		344,437	(92,580)	251,857			6
7	Other (specify):* Waste Disposal			15,667	15,667		15,667		15,667			7
8	**TOTAL General Services**	431,594	265,086	485,890	1,182,570		1,182,570	(95,455)	1,087,115			8
	B. Health Care and Programs											
9	Medical Director			5,541	5,541		5,541		5,541			9
10	Nursing and Medical Records	2,218,772	152,115	41,647	2,412,534		2,412,534	33,870	2,446,404			10
10a	Therapy	21,527	1,521		23,048		23,048	4,283	27,331			10a
11	Activities	76,009	4,273	775	81,057		81,057		81,057			11
12	Social Services	52,060	13	2,400	54,473		54,473		54,473			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,368,368	157,922	50,363	2,576,653		2,576,653	38,153	2,614,806			16
	C. General Administration											
17	Administrative	81,493		138,000	219,493		219,493	(125,852)	93,641			17
18	Directors Fees											18
19	Professional Services			272,662	272,662		272,662	(12,083)	260,579			19
20	Dues, Fees, Subscriptions & Promotions			18,765	18,765	1,028	19,793	(5,681)	14,112			20
21	Clerical & General Office Expenses	193,241	25,541	13,747	232,529		232,529	(45,068)	187,461			21
22	Employee Benefits & Payroll Taxes			401,479	401,479		401,479	20,161	421,640			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,856	1,856	(1,028)	828	4,844	5,672			24
25	Other Admin. Staff Transportation			5,785	5,785		5,785	3,313	9,098			25
26	Insurance-Prop.Liab.Malpractice			35,357	35,357		35,357	1,389	36,746			26
27	Other (specify):*											27
28	**TOTAL General Administration**	274,734	25,541	887,651	1,187,926		1,187,926	(158,977)	1,028,949			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,074,696	448,549	1,423,904	4,947,149		4,947,149	(216,279)	4,730,870			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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			2,478	2,478		2,478	2,097	4,575			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			143,628	143,628		143,628	(85,615)	58,013			32
33	Real Estate Taxes			192,006	192,006		192,006		192,006			33
34	Rent-Facility & Grounds			969,502	969,502		969,502		969,502			34
35	Rent-Equipment & Vehicles			44,510	44,510		44,510		44,510			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,352,124	1,352,124		1,352,124	(83,518)	1,268,606			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		219,341	670,690	890,031		890,031		890,031			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			180,344	180,344		180,344		180,344			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		219,341	851,034	1,070,375		1,070,375		1,070,375			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,074,696	667,890	3,627,062	7,369,648		7,369,648	(299,797)	7,069,851			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr St. Charles # 0049320 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,677)	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	(379)	32		10
11	Discounts, Allowances, Rebates & Refunds	(861)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(337)	2		13
14	Non-Care Related Interest	(143,628)	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	(3,496)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,601)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(616)	20		28
29	Other-Attach Schedule	(94,149)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (249,744)		$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 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)	(50,053)	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (50,053)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (299,797)		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 Yes	2 No	3 Amount	4 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

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Care Ctr St. Charles

ID# 0049320

Report Period Beginning: 7/1/2011

Ending: 6/30/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate Marketing Salary	$ (81,984)	21	1
2	Eliminate Marketing Mileage	(5,285)	25	2
3	Eliminate Lobbying & PAC Dues	(2,598)	20	3
4	IDPH License Fee	1,990	20	4
5	Eliminate Marketing Payroll Taxes	(6,272)	22	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**	(94,149)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Ctr St. Charles # 0049320 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,875)	0	0	0	0	0	0	0	0	0	0	(2,875)	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	(92,580)	0	0	0	0	0	0	0	0	(92,580)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,875)	0	(92,580)	0	0	0	0	0	0	0	0	(95,455)	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	33,870	0	0	0	0	0	0	0	0	0	33,870	10
10a	Therapy	0	4,283	0	0	0	0	0	0	0	0	0	4,283	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	38,153	0	0	0	0	0	0	0	0	0	38,153	16
	C. General Administration													
17	Administrative	0	(125,852)	0	0	0	0	0	0	0	0	0	(125,852)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,496)	329	(8,916)	0	0	0	0	0	0	0	0	(12,083)	19
20	Fees, Subscriptions & Promotions	(5,825)	16	128	0	0	0	0	0	0	0	0	(5,681)	20
21	Clerical & General Office Expenses	(81,984)	35,545	1,371	0	0	0	0	0	0	0	0	(45,068)	21
22	Employee Benefits & Payroll Taxes	(6,272)	19,372	7,061	0	0	0	0	0	0	0	0	20,161	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,817	3,027	0	0	0	0	0	0	0	0	4,844	24
25	Other Admin. Staff Transportation	(5,285)	2,699	5,899	0	0	0	0	0	0	0	0	3,313	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,389	0	0	0	0	0	0	0	0	1,389	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(102,862)	(66,074)	9,959	0	0	0	0	0	0	0	0	(158,977)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(105,737)	(27,921)	(82,621)	0	0	0	0	0	0	0	0	(216,279)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Ctr St. Charles # 0049320 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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

	Capital Expense D. Ownership	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)	
30	Depreciation	0	0	2,097	0	0	0	0	0	0	0	0	2,097	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(144,007)	0	58,392	0	0	0	0	0	0	0	0	(85,615)	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**	(144,007)	0	60,489	0	0	0	0	0	0	0	0	(83,518)	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
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(249,744)	(27,921)	(22,132)	0	0	0	0	0	0	0	0	(299,797)	45

Facility Name & ID Number Rosewood Care Ctr St. Charles # 0049320 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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		Supportive Living
		Bravo Care of East Peoria, Inc.	East Peoria, IL	River, Inc.	Wood River, IL	Facility
		Bravo Care of Edwardsville, Inc.	Edwardsville, IL	Bravo Nursing Home		
		Bravo Care of Elgin, Inc.	Elgin, IL	Services, Inc.	St. Louis, MO	Management Co.
		Bravo Care of Galesburg, Inc.	Galesburg, IL	Bravo Holding		
		Bravo Care of Inverness, Inc.	Inverness, IL	Company, Inc.	St. Louis, MO	Holding Co.
		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. [X] 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%	$ 33,870	$ 33,870	1
2	V	10a	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	4,283	4,283	2
3	V	19	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	329	329	3
4	V	20	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	16	16	4
5	V	21	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	35,545	35,545	5
6	V	22	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	19,372	19,372	6
7	V	24	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	1,817	1,817	7
8	V	25	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	2,699	2,699	8
9	V	17	Management Fees	138,000	Bravo Nursing Home Services, Inc.	100.00%	12,148	(125,852)	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 138,000			$ 110,079	$ * (27,921)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr St. Charles # 0049320 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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. [X] 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)	
15	V	6	Repairs & Maintenance	$ 217,632	Senior Living Services, Inc.		$ 125,052	$ (92,580)	15
16	V	21	Clerical & Office Expenses		Senior Living Services, Inc.		1,147	1,147	16
17	V	22	Payroll Taxes & Emp Ben.		Senior Living Services, Inc.		5,681	5,681	17
18	V	24	Travel & Seminar		Senior Living Services, Inc.		2,692	2,692	18
19	V	25	Other Admin Staff Transportation		Senior Living Services, Inc.		5,609	5,609	19
20	V	26	Insurance		Senior Living Services, Inc.		1,147	1,147	20
21	V	30	Depreciation		Senior Living Services, Inc.		2,097	2,097	21
22	V								22
23	V	19	Professional Services	23,150	Claims Administrative Services, LLC		10,743	(12,407)	23
24	V	20	Dues, Fees, & Subscriptions		Claims Administrative Services, LLC		28	28	24
25	V	21	Clerical & Office Expenses		Claims Administrative Services, LLC		224	224	25
26	V	22	Payroll Taxes & Emp Ben.		Claims Administrative Services, LLC		1,380	1,380	26
27	V	24	Travel & Seminar		Claims Administrative Services, LLC		335	335	27
28	V	25	Other Admin Staff Transportation		Claims Administrative Services, LLC		290	290	28
29	V								29
30	V	19	Professional Services		Bravo Holding Company		3,491	3,491	30
31	V	20	Dues, Fees, & Subscriptions		Bravo Holding Company		100	100	31
32	V	26	Insurance		Bravo Holding Company		242	242	32
33	V	32	Interest		Bravo Holding Company		58,392	58,392	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 240,782			$ 218,650	$ * (22,132)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr St. Charles # 0049320 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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	Senior Living		Building Services	1
2			Bravo Care of Northbrook, Inc.	Northbrook, IL	Services, Inc.	St. Louis, MO	Company	2
3			Bravo Care of Peoria, Inc.	Peoria, IL	Bravo Team		Human Resources	3
4			Bravo Care of Rockford, Inc.	Rockford, 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 Ctr St. Charles # 0049320 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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	2	3	4	5	6		7		8	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Michael Brady	President, Bravo	Administrative	0.00	175,299	3.89	6.48	Salary	$ 12,148	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	$ 12,148		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr St. Charles # 0049320 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing & Medical Records	Total Cost	108,055,422	15	$ 522,626	$ 522,626	7,002,700	$ 33,870	1
2	10a	Therapy	Total Cost	108,055,422	15	66,088	66,088	7,002,700	4,283	2
3	19	Professional Services	Total Cost	108,055,422	15	5,077		7,002,700	329	3
4	20	Dues & Subscriptions	Total Cost	108,055,422	15	252		7,002,700	16	4
5	21	Salaries-Other	Total Cost	108,055,422	15	535,914	535,914	7,002,700	34,731	5
6	21	Taxes, Licenses, & Office Sup	Total Cost	108,055,422	15	2,363		7,002,700	153	6
7	21	Telephone	Total Cost	108,055,422	15	10,197		7,002,700	661	7
8	22	Payroll Taxes	Total Cost	108,055,422	15	98,592		7,002,700	6,389	8
9	22	Employee Benefits	Total Cost	108,055,422	15	200,331		7,002,700	12,983	9
10	24	Travel & Seminar	Total Cost	108,055,422	15	28,031		7,002,700	1,817	10
11	25	Administrative Transportation	Total Cost	108,055,422	15	41,648		7,002,700	2,699	11
12	17	Salaries - Officer	Total Cost	108,055,422	15	187,446	187,446	7,002,700	12,148	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		$ 110,079	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr St. Charles # 0049320 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bravo Holding Co. Cost Allocation			Revolving Line of Credit		8/1/09		2,858,228	12/31/14	5.0000	58,392	6
7												7
8	Less: Interest Income Offset										(379)	8
9	TOTAL Facility Related						$	$ 2,858,228			$ 58,013	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 2,858,228			$ 58,013	15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rosewood Care Ctr St. Charles # 0049320 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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.	$	159,502	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.)	$	170,337	2
3. Under or (over) accrual (line 2 minus line 1).	$	10,835	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)	$	181,171	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.	$	192,006	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2007	129,263	8
2008	150,191	9
2009	143,936	10
2010	159,502	11
2011	181,171	12

2010 Payment = $79,751
2011 Payment = $90,586
Accrual = Remaining balance of 2011 tax bill ($90,586) + 1/2 extimated 2012 tax bill ($90,585)

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.** This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rosewood Care Ctr St. Charles COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0049320

CONTACT PERSON REGARDING THIS REPORT Chuck Schmitz

TELEPHONE (314)994-9070 FAX #: (314)994-9112

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

	(A)	(B)	(C)	(D)
	Tax Index Number	**Property Description**	**Total Tax**	**Tax Applicable to Nursing Home**
1.	09-26-226-008	850 Dunham Road	$ 181,171.34	$ 181,171.34
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 181,171.34	$ 181,171.34

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ________ YES _X_______ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 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 Ctr St. Charles # 0049320 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,252 B. General Construction Type: Exterior Brick Veneer Frame Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (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. [X] (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 [X] 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	Schedule N/A			$	1
2					2
3	TOTALS			$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr St. Charles # 0049320 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Carpet Installation			2009	13,142	1,878	7	1,878		6,102	9
10	Acrovyn for Walls, Doors			2009	4,206	600	7	600		1,652	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

Facility Name & ID Number Rosewood Care Ctr St. Charles # 0049320 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Building Improvements made by lessor 12/1/07-6/30/12		$	$		$	$	$	37
38	Cooling Tower	2008	118,482						38
39	Compressors	2008	5,194						39
40	Heat Pumps	2009	7,438						40
41	Healthcare TV Package	2010	14,548						41
42	Toshiba Phone System	2010	21,200						42
43	Water Heater Piping	2010	9,494						43
44	Doors	2010	4,034						44
45	Boiler	2010	18,074						45
46	Seal Coat Parking Lot	2010	5,104						46
47	Roof Replacement	2011	6,600						47
48	HVAC	2011	6,961						48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 234,477	$ 2,478		$ 2,478	$	$ 7,754	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Rosewood Care Ctr St. Charles # 0049320 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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	$ 19,030	$	$ 2,097	$ 2,097	4	$ 13,359	76
77										77
78										78
79										79
80	TOTALS			$ 19,030	$	$ 2,097	$ 2,097		$ 13,359	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)	$ 253,507	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 2,478	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 4,575	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,097	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 21,113	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.

SEE ACCOUNTANTS' COMPILATION REPORT

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number: Rosewood Care Ctr St. Charles # 0049320 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: St. Charles Real Estate, L.L.C.
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. [X] 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:	1999	109	12/1/07	$ 969,502	5	Unlimited	3
4	Additions							4
5								5
6								6
7	TOTAL		109		$ 969,502 **			7

10. Effective dates of current rental agreement:
    Beginning 12/1/07
    Ending 10/31/12

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

	Fiscal Year Ending	Annual Rent
12.	6/30/2013	$ 332,800
13.	/2014	$
14.	/2015	$

8. List separately any amortization of lease expense included on page 4, line 34. None
   This amount was calculated by dividing the total amount to be amortized N/A
   by the length of the lease N/A .

9. Option to Buy: [ ] YES [X] NO Terms: N/A *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] 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	Schedule Not Applicable		$	$	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 Ctr St. Charles # 0049320 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES

[X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]

IN OTHER FACILITY [ ]

COMMUNITY COLLEGE [ ]

HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]

IN OTHER FACILITY [ ]

HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
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				1,521		1,521	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				219,341		219,341	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): Labs,X-Rays,Enterals	39,3				670,690			670,690	13
14	TOTAL			$		$ 670,690	$ 220,862		$ 891,552	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 Ctr St. Charles # 0049320 **Report Period Beginning:** 7/1/2011 **Ending:** 6/30/2012

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/2012 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 8,608	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 95,000)	981,469		3
4	Supply Inventory (priced at Cost)	3,016		4
5	Short-Term Investments			5
6	Prepaid Insurance	24,003		6
7	Other Prepaid Expenses	3,120		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,020,216	$	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	17,348		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(7,754)		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): Deposits	2,000		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 11,594	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,031,810	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 270,641	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	238,806		30
31	Accrued Taxes Payable (excluding real estate taxes)	30,407		31
32	Accrued Real Estate Taxes(Sch.IX-B)	181,171		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	1,605		35
	Other Current Liabilities(specify):			
36	Accrued Expenses	138,203		36
37	Accrued Rent	90,158		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 950,991	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,858,228		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)**	$ 2,858,228	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,809,219	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,777,409)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,031,810	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Rosewood Care Ctr St. Charles # 0049320 **Report Period Beginning:** 7/1/2011 **Ending:** 6/30/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,028,123)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,028,123)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(749,286)	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)**	$ (749,286)	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)**	$ (2,777,409)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr St. Charles # 0049320 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,746,780	1
2	Discounts and Allowances for all Levels	(1,745,445)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,001,335	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,595,721	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,595,721	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	3,900	13
14	Non-Patient Meals	1,677	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)**	$ 5,577	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	379	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 379	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Attached Schedule	17,350	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 17,350	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,620,362	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,182,570	31
32	Health Care	2,576,653	32
33	General Administration	1,187,926	33
	B. Capital Expense		
34	Ownership	1,352,124	34
	C. Ancillary Expense		
35	Special Cost Centers	1,070,375	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,369,648	40
41	**Income before Income Taxes (line 30 minus line 40)****	(749,286)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (749,286)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,548,680	44
45	Private Pay - Net Inpatient Revenue	1,874,290	45
46	Medicare - Net Inpatient Revenue	1,495,221	46
47	Other-(specify) Managed Care - Net Inpatient Revenue	83,144	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,001,335	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 Ctr St. Charles # 0049320 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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	1,967	2,101	$ 75,059	$ 35.73	1
2	Assistant Director of Nursing	1,980	2,115	73,181	34.60	2
3	Registered Nurses	20,008	21,373	678,097	31.73	3
4	Licensed Practical Nurses	17,954	19,179	481,187	25.09	4
5	CNAs & Orderlies	58,327	63,306	805,173	12.72	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,140	1,218	21,527	17.67	8
9	Activity Director					9
10	Activity Assistants	4,962	5,301	76,009	14.34	10
11	Social Service Workers	3,663	3,913	52,060	13.30	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,354	20,675	210,412	10.18	15
16	Dishwashers					16
17	Maintenance Workers	2,188	2,337	37,609	16.09	17
18	Housekeepers	15,500	16,557	162,119	9.79	18
19	Laundry	2,249	2,402	21,454	8.93	19
20	Administrator	1,814	1,938	81,493	42.05	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,192	13,023	193,241	14.84	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	5,363	5,729	106,075	18.52	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	168,661	181,167	$ 3,074,696 *	$ 16.97	34

SEE ACCOUNTANTS' COMPILATION REPORT

* 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	$ 9,516	1,3	35
36	Medical Director	Contract	5,541	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	3,808	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	775	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)		$ 22,040		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	445	$ 22,442	10-3	50
51	Licensed Practical Nurses	363	15,397	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	808	$ 37,839		53

Facility Name & ID Number Rosewood Care Ctr St. Charles # 0049320 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kathryn Dyhouse	Administrator	0	$ 46,981
Joli Koch	Administrator	0	5,118
Ivy Gleeson	Administrator	0	29,394
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 81,493

B. Administrative - Other

Description	Amount
Bravo Nursing Home Services	$ 138,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 138,000

C. Professional Services

Vendor/Payee	Type	Amount
See Attached		$ 272,662
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 272,662

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 56,068
Unemployment Compensation Insurance	77,034
FICA Taxes	224,334
Employee Health Insurance	30,845
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	1,448
Employee Uniforms	1,026
Employee Physicals	4,452
Related Party Allocation	26,433
TOTAL (agree to Schedule V, line 22, col.8)	$ 421,640

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
Section Not Applicable		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	849
Health Care Worker Background Check	3,460
(Indicate # of checks performed)	
Patient Background Checks	
IHCA Dues	3,641
Misc. Dues/Subscriptions	1,028
Rosewood License Fee	3,000
Promotional Advertising	5,217
Related Party Allocation	144
Less: Public Relations Expense	( )
Non-allowable advertising	(4,601)
Yellow page advertising	(616)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,112

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Related Party Allocation	4,844
Seminar Expense	828
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,672

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr St. Charles # 0049320 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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
					Amount of Expense Amortized Per Year								
	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

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 $3,641**

(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. $ **45,965** 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. $ **180,344**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(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. $ **No** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,677**

(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? **N/A** 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. $ **No**

(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 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? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Bravo Care Center of St. Charles
Attachment to Schedule XII D
Other Revenue
6/30/2012

	Description	
28A	Vendor Discount	$ 861
28B	Miscellaneous Income	1,247
28C	Accounts Receivable Adjustment	14,855
28D	Vending Income	387
		$ 17,350

Bravo Care of St. Charles, Inc.
Attachment to Schedule XIX C
6/30/2012

Vendor	Type	Amount
C.J. Schlosser & Company	Accountant/Consultant	4,145
Daniel Maher	Collections & Out-of-period Fees	3,231
Daniel Maher	Allowable Legal Fees	6,568
Midwest Administrative Services	Administrative/Bookkeeping	206,827
Kelly, Olson, Michod, DeHaan, Richter	Real Estate Tax Appeal	11,447
Kelly, Olson, Michod, DeHaan, Richter	Out-of-period Fees	247
James O Hamilton & Co.	Real Estate Tax Appeal	5,000
Marsh USA	Bond Renewal	100
Mulherin, Rehfeldt & Varchetto, P.C.	Allowable Legal Fees	3,216
Mulherin, Rehfeldt & Varchetto, P.C.	Out-of-period Fees	18
Laner, Muchin, et. Al., Ltd.	Allowable Legal Fees	7,635
Kane County Circuit Court	Court Fees	136
Gore Perry Reporting & Video	Deposition Transcription	169
Record Copy Services	Deposition Transcription	140
Urbanski Reporting Company, Inc.	Deposition Transcription	411
McCorkle Court Reporters, Inc.	Deposition Transcription	222
Claims Administration Services, Inc.	Related Party Legal Fees	23,150
		272,662