		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.

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

I. IDPH License ID Number: 0049270

Facility Name: Rosewood Care Ctr of Rockford

Address: 1660 S Mulford Rd (Number) Rockford (City) 61108 (Zip Code)

County: Winnebago

Telephone Number: (815)397-8700 **Fax #** (815)397-4880

HFS ID Number:

Date of Initial License for Current Owners: 12/1/2007

Type of Ownership:

	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 7/1/2012 to 6/30/2013 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 of Rockford # 0049270 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			6,334	6,334	8
9	SNF/PED					9
10	ICF	11,859	9,961		21,820	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,859	9,961	6,334	28,154	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.28%

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 [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 58 and days of care provided 6,334

Medicare Intermediary Novitas Solutions, Inc.

IV. ACCOUNTING BASIS

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

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/13 Fiscal Year: 6/30/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Rockford # 0049270 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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	225,825	20,305	16,245	262,375		262,375		262,375			1
2	Food Purchase		179,718		179,718		179,718	(4,173)	175,545			2
3	Housekeeping	130,892	27,518		158,410		158,410		158,410			3
4	Laundry	48,719	15,508		64,227		64,227		64,227			4
5	Heat and Other Utilities			118,340	118,340		118,340		118,340			5
6	Maintenance	19,781	8,297	167,176	195,254		195,254	(37,344)	157,910			6
7	Other (specify):* Waste Disposal			16,075	16,075		16,075		16,075			7
8	TOTAL General Services	425,217	251,346	317,836	994,399		994,399	(41,517)	952,882			8
	B. Health Care and Programs											
9	Medical Director			2,625	2,625		2,625		2,625			9
10	Nursing and Medical Records	2,223,717	195,658	42,489	2,461,864		2,461,864	33,886	2,495,750			10
10a	Therapy	69,304	1,584		70,888		70,888		70,888			10a
11	Activities	61,410	5,535	2,400	69,345		69,345		69,345			11
12	Social Services	56,180		2,400	58,580		58,580		58,580			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,410,611	202,777	49,914	2,663,302		2,663,302	33,886	2,697,188			16
	C. General Administration											
17	Administrative	85,060		138,000	223,060		223,060	(126,166)	96,894			17
18	Directors Fees											18
19	Professional Services			243,316	243,316		243,316	8,487	251,803			19
20	Dues, Fees, Subscriptions & Promotions			33,895	33,895	2,430	36,325	(5,952)	30,373			20
21	Clerical & General Office Expenses	175,093	29,573	51,133	255,799		255,799	(66,046)	189,753			21
22	Employee Benefits & Payroll Taxes			423,558	423,558		423,558	12,535	436,093			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,530	2,530	(2,430)	100	2,519	2,619			24
25	Other Admin. Staff Transportation			4,572	4,572		4,572	629	5,201			25
26	Insurance-Prop.Liab.Malpractice			56,950	56,950		56,950	1,318	58,268			26
27	Other (specify):*											27
28	TOTAL General Administration	260,153	29,573	953,954	1,243,680		1,243,680	(172,676)	1,071,004			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,095,981	483,696	1,321,704	4,901,381		4,901,381	(180,307)	4,721,074			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rosewood Care Ctr of Rockford #0049270 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			5,487	5,487		5,487	1,126	6,613			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			92,809	92,809		92,809	(55,252)	37,557			32
33	Real Estate Taxes			117,638	117,638		117,638		117,638			33
34	Rent-Facility & Grounds			837,037	837,037		837,037		837,037			34
35	Rent-Equipment & Vehicles			104,421	104,421		104,421		104,421			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,157,392	1,157,392		1,157,392	(54,126)	1,103,266			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		273,292	823,965	1,097,257		1,097,257		1,097,257			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			202,099	202,099		202,099		202,099			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		273,292	1,026,064	1,299,356		1,299,356		1,299,356			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,095,981	756,988	3,505,160	7,358,129		7,358,129	(234,433)	7,123,696			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 of Rockford # 0049270 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,518)	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	(2,410)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,340)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(315)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(32,895)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(12,630)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,986)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(322)	20		28
29	Other-Attach Schedule	(83,036)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (138,452)		$	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)	(95,981)	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (95,981)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (234,433)		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 of Rockford

ID# 0049270

Report Period Beginning: 7/1/2012

Ending: 6/30/2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate Marketing Salary	$ (70,417)	21	1
2	Eliminate Marketing Payroll Taxes	(5,387)	22	2
3	Eliminate Marketing Mileage	(4,263)	25	3
4	Eliminate Lobbying & PAC Dues	(2,969)	20	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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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**	(83,036)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Ctr of Rockford # 0049270 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,173)	0	0	0	0	0	0	0	0	0	0	(4,173)	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	(37,344)	0	0	0	0	0	0	0	0	(37,344)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,173)	0	(37,344)	0	0	0	0	0	0	0	0	(41,517)	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	33,886	0	0	0	0	0	0	0	0	0	33,886	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	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	33,886	0	0	0	0	0	0	0	0	0	33,886	16
	C. General Administration													
17	Administrative	0	(126,166)	0	0	0	0	0	0	0	0	0	(126,166)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(12,630)	405	20,712	0	0	0	0	0	0	0	0	8,487	19
20	Fees, Subscriptions & Promotions	(6,277)	17	308	0	0	0	0	0	0	0	0	(5,952)	20
21	Clerical & General Office Expenses	(103,312)	36,782	484	0	0	0	0	0	0	0	0	(66,046)	21
22	Employee Benefits & Payroll Taxes	(5,387)	15,161	2,761	0	0	0	0	0	0	0	0	12,535	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,207	1,312	0	0	0	0	0	0	0	0	2,519	24
25	Other Admin. Staff Transportation	(4,263)	2,530	2,362	0	0	0	0	0	0	0	0	629	25
26	Insurance-Prop.Liab.Malpractice	0	268	1,050	0	0	0	0	0	0	0	0	1,318	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(131,869)	(69,796)	28,989	0	0	0	0	0	0	0	0	(172,676)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(136,042)	(35,910)	(8,355)	0	0	0	0	0	0	0	0	(180,307)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Ctr of Rockford # 0049270 **Report Period Beginning:** 7/1/2012 **Ending:** 6/30/2013

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	1,126	0	0	0	0	0	0	0	0	1,126	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,410)	0	(52,842)	0	0	0	0	0	0	0	0	(55,252)	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**	(2,410)	0	(51,716)	0	0	0	0	0	0	0	0	(54,126)	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)**	(138,452)	(35,910)	(60,071)	0	0	0	0	0	0	0	0	(234,433)	45

Facility Name & ID Number Rosewood Care Ctr of Rockford # 0049270 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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 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%	$ 33,886	$ 33,886	1
2	V	17	Management Fees	138,000	Bravo Nursing Home Services, Inc.	100.00%	11,834	(126,166)	2
3	V	19	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	405	405	3
4	V	20	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	17	17	4
5	V	21	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	36,782	36,782	5
6	V	22	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	15,161	15,161	6
7	V	24	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	1,207	1,207	7
8	V	25	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	2,530	2,530	8
9	V	26	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	268	268	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 138,000			$ 102,090	$ * (35,910)	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 of Rockford # 0049270 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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	$ 91,762	Senior Living Services, Inc.		$ 54,418	$ (37,344)	15
16	V	21	Clerical & Office Expenses		Senior Living Services, Inc.		456	456	16
17	V	22	Payroll Taxes & Emp Ben.		Senior Living Services, Inc.		2,509	2,509	17
18	V	24	Travel & Seminar		Senior Living Services, Inc.		1,283	1,283	18
19	V	25	Other Admin Staff Transportation		Senior Living Services, Inc.		2,327	2,327	19
20	V	26	Insurance		Senior Living Services, Inc.		499	499	20
21	V	30	Depreciation		Senior Living Services, Inc.		1,126	1,126	21
22	V								22
23	V	19	Professional Services	3,188	Claims Administrative Services, LLC		17,575	14,387	23
24	V								24
25	V	21	Clerical & Office Expenses		Claims Administrative Services, LLC		28	28	25
26	V	22	Payroll Taxes & Emp Ben.		Claims Administrative Services, LLC		252	252	26
27	V	24	Travel & Seminar		Claims Administrative Services, LLC		29	29	27
28	V	25	Other Admin Staff Transportation		Claims Administrative Services, LLC		35	35	28
29	V								29
30	V	19	Professional Services		Bravo Holding Company		6,325	6,325	30
31	V	20	Dues, Fees, & Subscriptions		Bravo Holding Company		308	308	31
32	V	26	Insurance		Bravo Holding Company		551	551	32
33	V	32	Interest	92,809	Bravo Holding Company		39,967	(52,842)	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 187,759			$ 127,688	$ * (60,071)	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 of Rockford # 0049270 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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 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 Ctr of Rockford # 0049270 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	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 Reference	
						Hours	Percent	Description	Amount		
1	Michael Brady	President, Bravo	Administrative	0.00	171,782	3.87	6.45	Salary	$ 11,834	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	$ 11,834		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 of Rockford # 0049270 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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 [ ]

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 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	109,821,039	15	$ 525,769	$ 525,769	7,078,093	$ 33,886	1
2	17	Salaries-Officer	Total Cost	109,821,039	15	183,617	183,617	7,078,093	11,834	2
3	19	Professional Services	Total Cost	109,821,039	15	6,285		7,078,093	405	3
4	20	Dues & Subscriptions	Total Cost	109,821,039	15	264		7,078,093	17	4
5	21	Salaries-Other	Total Cost	109,821,039	15	558,202	558,202	7,078,093	35,977	5
6	21	Taxes, Licenses, & Office Sup	Total Cost	109,821,039	15	1,944		7,078,093	125	6
7	21	Telephone	Total Cost	109,821,039	15	10,557		7,078,093	680	7
8	22	Payroll Taxes	Total Cost	109,821,039	15	91,380		7,078,093	5,890	8
9	22	Employee Benefits	Total Cost	109,821,039	15	143,842		7,078,093	9,271	9
10	24	Travel & Seminar	Total Cost	109,821,039	15	18,727		7,078,093	1,207	10
11	25	Administrative Transportation	Total Cost	109,821,039	15	39,261		7,078,093	2,530	11
12	26	Insurance	Total Cost	109,821,039	15	4,163		7,078,093	268	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					$ 1,584,011	$ 1,267,588		$ 102,090	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Rockford # 0049270 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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		2,026,872	12/31/14	5.0000	39,967	6
7												7
8	Less: Interest Income Offset										(2,410)	8
9	TOTAL Facility Related						$	$ 2,026,872			$ 37,557	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 2,026,872			$ 37,557	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 of Rockford # 0049270 **Report Period Beginning:** 7/1/2012 **Ending:** 6/30/2013

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 120,950	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.)		$ 119,052	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,898)	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 119,536	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.		$ 117,638	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	104,645	8
	2009	109,792	9
	2010	115,223	10
	2011	119,752	11
	2012	118,352	12

2011 Tax Paymen = 59876
2012 Tax Paymen = 59176
Accrual = Remaining balance of 2012 Tax Bill 59176 + 1/2 estimated 2013 Tax Bill 60360

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rosewood Care Ctr of Rockford COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0049270

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 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	12-34-102-022	Rosewood Sub	$ 118,352.00	$ 118,352.00
2.		Pt NW 1/4 Sec 34-44-2 Lot 1	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 118,352.00	$ 118,352.00

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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 of Rockford # 0049270 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 41,042 B. General Construction Type: Exterior Stucco Frame Wood 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Schedule N/A			$	1
2					2
3	TOTALS			$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Rockford # 0049270 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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	Painting			2008	21,667	3,095	7	3,095		16,135	9
10	Acrovyn for Doors/Walls/Shelves			2008	5,454	778	7	778		3,636	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 of Rockford # 0049270 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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 12/1/07-6/30/13		$	$		$	$	$	37
38	Carpet for Lobby & Admin Offices	2008	2,764						38
39	Seal and Stripe Parking Lot	2008	4,358						39
40	Dumpster Enclosure	2008	3,200						40
41	Carpet for Lobby & Admin Offices	2009	13,050						41
42	New Doors	2010	4,685						42
43	Doors	2001	14,504						43
44	Attic Sprinklers	2010	4,750						44
45	Seal Coat Parking Lot	2010	5,025						45
46	Tuckpointing	2010	15,360						46
47	HVAC	2011	3,992						47
48	Boiler	2011	5,864						48
49	Water Heater	2012	3,084						49
50	Cooling Tower	2012	103,854						50
51	HVAC Units	2012	3,152						51
52	4 HVAC Units	2013	11,807						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)		$ 226,570	$ 3,873		$ 3,873	$	$ 19,771	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 of Rockford # 0049270 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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	$	$	$	$		$	71
72	Current Year Purchases	46,589	1,614	1,614			1,614	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 46,589	$ 1,614	$ 1,614	$		$ 1,614	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	$ 7,504	$	$ 1,126	$ 1,126	4	$ 6,395	76
77										77
78										78
79										79
80	TOTALS			$ 7,504	$	$ 1,126	$ 1,126		$ 6,395	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)	$ 280,663	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 5,487	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 6,613	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,126	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 27,780	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

Facility Name & ID Number Rosewood Care Ctr of Rockford # 0049270 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Rockford 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:	1996	120	12/1/07	$ 837,037	5	Unlimited	3
4	Additions							4
5								5
6								6
7	TOTAL		120		$ 837,037 **			7

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 *

10. Effective dates of current rental agreement:
    Beginning 12/1/07
    Ending 10/31/13

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

	Fiscal Year Ending	Annual Rent
12.	6/30/2014	$ 299,959
13.	6/30/2015	$
14.	6/30/2016	$

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 of Rockford # 0049270 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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

Facility Name & ID Number Rosewood Care Ctr of Rockford # 0049270 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,2	hrs				1,584		1,584	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				273,292		273,292	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				823,965			823,965	13
14	TOTAL			$		$ 823,965	$ 274,876		$ 1,098,841	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 of Rockford # 0049270 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2013 (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	$ 40,410	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 27,009)	1,210,862		3
4	Supply Inventory (priced at Cost)	3,082		4
5	Short-Term Investments			5
6	Prepaid Insurance	30,589		6
7	Other Prepaid Expenses	6,308		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,291,251	$	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	27,121		15
16	Equipment, at Historical Cost	46,589		16
17	Accumulated Depreciation (book methods)	(21,385)		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)**	$ 54,325	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,345,576	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 260,037	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	259,716		30
31	Accrued Taxes Payable (excluding real estate taxes)	32,602		31
32	Accrued Real Estate Taxes(Sch.IX-B)	119,536		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	3,529		35
	Other Current Liabilities(specify):			
36	Accrued Expenses	72,064		36
37	Accrued Rent	49,735		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 797,219	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,026,872		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)**	$ 2,026,872	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,824,091	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,478,515)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,345,576	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Rosewood Care Ctr of Rockford # 0049270 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (849,821)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (849,821)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(628,694)	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)**	$ (628,694)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,478,515)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Rockford # 0049270 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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	$ 6,918,938	1
2	Discounts and Allowances for all Levels	(2,227,443)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,691,495	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,024,265	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,024,265	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	3,125	13
14	Non-Patient Meals	2,518	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)**	$ 5,643	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,410	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,410	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attachment	7,017	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,017	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,730,830	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	994,399	31
32	Health Care	2,663,302	32
33	General Administration	1,243,680	33
	B. Capital Expense		
34	Ownership	1,157,392	34
	C. Ancillary Expense		
35	Special Cost Centers	1,097,257	35
36	Provider Participation Fee	202,099	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,358,129	40
41	**Income before Income Taxes (line 30 minus line 40)****	(627,299)	41
42	**Income Taxes**	(1,395)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (628,694)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,454,936	44
45	Private Pay - Net Inpatient Revenue	1,507,865	45
46	Medicare - Net Inpatient Revenue	1,410,136	46
47	Other-(specify) Managed Care	318,558	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,691,495	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 of Rockford # 0049270 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,547	1,653	$ 57,000	$ 34.48	1
2	Assistant Director of Nursing	1,695	1,935	54,971	28.41	2
3	Registered Nurses	28,613	30,629	868,191	28.35	3
4	Licensed Practical Nurses	17,178	18,353	445,439	24.27	4
5	CNAs & Orderlies	64,304	67,798	757,380	11.17	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,422	3,767	69,304	18.40	8
9	Activity Director					9
10	Activity Assistants	5,176	5,497	61,410	11.17	10
11	Social Service Workers	4,359	4,544	56,180	12.36	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,037	23,303	225,825	9.69	15
16	Dishwashers					16
17	Maintenance Workers	1,849	1,948	19,781	10.15	17
18	Housekeepers	11,789	12,961	130,892	10.10	18
19	Laundry	5,178	5,370	48,719	9.07	19
20	Administrator	1,879	2,046	85,060	41.57	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,839	12,835	175,093	13.64	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,272	2,622	40,736	15.54	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	183,137	195,261	$ 3,095,981 *	$ 15.86	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Contract	$ 16,245	1,3	35
36	Medical Director	Contract	2,625	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	7,925	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)		$ 31,595		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	574	$ 23,831	10-3	50
51	Licensed Practical Nurses	298	10,733	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	872	$ 34,564		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Rosewood Care Ctr of Rockford # 0049270 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Bart Becker	Administrator	0	$ 85,060
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 85,060

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
C.J. Schlosser & Company	Accountant/Consultant	$ 4,450
Daniel Maher	Collections & Out of Period	12,630
Daniel Maher	Allowable Legal Fees	11,919
Midwest Administrative Services	Administrative Fees	210,929
Marsh USA	Bond Renewal	200
Claims Administration Services, Inc.	Related Party Legal Fees	3,188
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 243,316

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 72,728
Unemployment Compensation Insurance	77,872
FICA Taxes	227,343
Employee Health Insurance	33,569
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	1,967
Employee Uniforms	1,082
Employee Physicals & Vaccinations	2,949
Related Party Allocation	17,922
Employee Drug Tests	562
Tuition Reimbursement	99
TOTAL (agree to Schedule V, line 22, col.8)	$ 436,093

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	12,185
Health Care Worker Background Check	8,183
(Indicate # of checks performed)	
Patient Background Checks	
IHCA Dues	3,900
Misc. Dues/Subscriptions	790
Rosewood License Fee	3,000
Promotional Advertising	3,308
Related Party Allocation	325
Less: Public Relations Expense	( )
Non-allowable advertising	(2,986)
Yellow page advertising	(322)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 30,373

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Related Party Expense	2,519
Seminar Expense	100
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,619

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Rockford # 0049270 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Rockford # 0049270 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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 3900**

(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? **5 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **48,066** 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. $ **202,099**
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. $ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,518**

(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 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 Rockford
Attachment to Schedule XII E
Other Revenue
6/30/2013

	Description	
28A	Vendor Discount	$1,340
28B	Miscellaneaous Income	3984
28C	Vending Income	1693
		$7,017