

Facility Name & ID Number Rosewood Care Ctr St. Charles

0049320 Report Period Beginning: 7/1/08 Ending: 6/30/09

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	109	Skilled (SNF)	109	39,785	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	39,785	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF			4,647	4,647	8
9	SNF/PED					9
10	ICF	6,737	15,019		21,756	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,737	15,019	4,647	26,403	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.36%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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

I. On what date did you start providing long term care at this location?
Date started 12/1/07

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 38 and days of care provided 4,647

Medicare Intermediary Palmetto GBA

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/09 Fiscal Year: 6/30/09

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

Facility Name & ID Number Rosewood Care Ctr St. Charles # 0049320 Report Period Beginning: 7/1/08 Ending: 6/30/09

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	204,610	24,544	7,014	236,168		236,168		236,168		1
2	Food Purchase		156,307		156,307		156,307	(2,186)	154,121		2
3	Housekeeping	127,087	32,274		159,361		159,361		159,361		3
4	Laundry	23,204	11,248		34,452		34,452		34,452		4
5	Heat and Other Utilities			136,074	136,074		136,074		136,074		5
6	Maintenance	35,948	27,430	278,348	341,726		341,726	(45,112)	296,614		6
7	Other (specify):* Garbage Removal			11,042	11,042		11,042		11,042		7
8	TOTAL General Services	390,849	251,803	432,478	1,075,130		1,075,130	(47,298)	1,027,832		8
	B. Health Care and Programs										
9	Medical Director			4,125	4,125		4,125		4,125		9
10	Nursing and Medical Records	1,924,434	142,267	446,155	2,512,856		2,512,856		2,512,856		10
10a	Therapy	18,950	2,630	362,319	383,899		383,899	(45,246)	338,653		10a
11	Activities	68,362	5,375	980	74,717		74,717		74,717		11
12	Social Services	55,876		1,256	57,132		57,132		57,132		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,067,622	150,272	814,835	3,032,729		3,032,729	(45,246)	2,987,483		16
	C. General Administration										
17	Administrative	39,101		138,000	177,101		177,101	(138,000)	39,101		17
18	Directors Fees										18
19	Professional Services			171,377	171,377		171,377	(13,600)	157,777		19
20	Dues, Fees, Subscriptions & Promotions			27,546	27,546	2,926	30,472	(11,769)	18,703		20
21	Clerical & General Office Expenses	201,238	21,507	30,381	253,126		253,126	(9,650)	243,476		21
22	Employee Benefits & Payroll Taxes			343,606	343,606		343,606	9,361	352,967		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,249	5,249	(2,926)	2,323	6,715	9,038		24
25	Other Admin. Staff Transportation			16,985	16,985		16,985	(5,764)	11,221		25
26	Insurance-Prop.Liab.Malpractice			55,490	55,490		55,490	2,935	58,425		26
27	Other (specify):*										27
28	TOTAL General Administration	240,339	21,507	788,634	1,050,480		1,050,480	(159,772)	890,708		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,698,810	423,582	2,035,947	5,158,339		5,158,339	(252,316)	4,906,023		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 St. Charles

#0049320

Report Period Beginning:

7/1/08

Ending:

6/30/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			469	469		469	4,152	4,621			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			40,229	40,229		40,229	(40,229)				32
33	Real Estate Taxes			153,933	153,933		153,933		153,933			33
34	Rent-Facility & Grounds			1,008,595	1,008,595		1,008,595		1,008,595			34
35	Rent-Equipment & Vehicles			20,708	20,708		20,708		20,708			35
36	Other (specify):*											36
37	TOTAL Ownership			1,223,934	1,223,934		1,223,934	(36,077)	1,187,857			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		141,968	30,049	172,017		172,017		172,017			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			59,678	59,678		59,678		59,678			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		141,968	89,727	231,695		231,695		231,695			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,698,810	565,550	3,349,608	6,613,968		6,613,968	(288,393)	6,325,575			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:

7/1/08

Ending:

6/30/09

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,365)	2		4
5	Telephone, TV & Radio in Resident Rooms	(398)	21		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				10
11	Discounts, Allowances, Rebates & Refunds	(381)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(440)	2		13
14	Non-Care Related Interest	(40,229)	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	(91)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(14,477)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(3,127)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,174)	20		28
29	Other-Attach Schedule See Attached	(129,767)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (194,449)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(93,944)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (93,944)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (288,393)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Care Ctr St. Charles

ID# 0049320

Report Period Beginning: 7/1/08

Ending: 6/30/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Marketing Salary	\$ (98,456)	21	1
2	Marketing Mileage	(14,823)	25	2
3	Worker's Comp Dividend	(12,000)	22	3
4	Lobbying & PAC Dues	(3,147)	20	4
5	Out of Period IDPH License Fees	(1,341)	20	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(129,767)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Ctr St. Charles# 0049320

Report Period Beginning:

7/1/08

Ending:

6/30/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,186)	0	0	0	0	0	0	0	0	0	0	(2,186)	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	3	(45,115)	0	0	0	0	0	0	0	0	(45,112)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,186)	3	(45,115)	0	(47,298)	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	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	(45,246)	0	0	0	0	0	0	0	0	0	(45,246)	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	(45,246)	0	0	0	0	0	0	0	0	0	(45,246)	16
	C. General Administration													
17	Administrative	0	(138,000)	0	0	0	0	0	0	0	0	0	(138,000)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(14,477)	877	0	0	0	0	0	0	0	0	0	(13,600)	19
20	Fees, Subscriptions & Promotions	(11,789)	20	0	0	0	0	0	0	0	0	0	(11,769)	20
21	Clerical & General Office Expenses	(98,854)	87,622	1,582	0	0	0	0	0	0	0	0	(9,650)	21
22	Employee Benefits & Payroll Taxes	(12,000)	13,979	7,382	0	0	0	0	0	0	0	0	9,361	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(91)	2,906	3,900	0	0	0	0	0	0	0	0	6,715	24
25	Other Admin. Staff Transportation	(14,823)	2,658	6,401	0	0	0	0	0	0	0	0	(5,764)	25
26	Insurance-Prop.Liab.Malpractice	0	1,485	1,450	0	0	0	0	0	0	0	0	2,935	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(152,034)	(28,453)	20,715	0	(159,772)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(154,220)	(73,696)	(24,400)	0	(252,316)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Ctr St. Charles# 0049320

Report Period Beginning:

7/1/08

Ending:

6/30/09

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	4,152	0	0	0	0	0	0	0	0	4,152	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(40,229)	0	0	0	0	0	0	0	0	0	0	(40,229)	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	(40,229)	0	4,152	0	(36,077)	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(194,449)	(73,696)	(20,248)	0	(288,393)	45							

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>Bravo Services, L.L.C.</u>	<u>100</u>	<u>See Attached</u>		<u>See Attached</u>		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	6 <u>See Schedule VIII</u>	\$	<u>Bravo Nursing Home Services, Inc.</u>	100.00%	\$ 3	\$ 3	1
2	V	17 <u>Management Fees</u>	138,000	<u>Bravo Nursing Home Services, Inc.</u>	100.00%		(138,000)	2
3	V	19 <u>See Schedule VIII</u>		<u>Bravo Nursing Home Services, Inc.</u>	100.00%	877	877	3
4	V	20 <u>See Schedule VIII</u>		<u>Bravo Nursing Home Services, Inc.</u>	100.00%	20	20	4
5	V	21 <u>See Schedule VIII</u>		<u>Bravo Nursing Home Services, Inc.</u>	100.00%	87,622	87,622	5
6	V	22 <u>See Schedule VIII</u>		<u>Bravo Nursing Home Services, Inc.</u>	100.00%	13,979	13,979	6
7	V	24 <u>See Schedule VIII</u>		<u>Bravo Nursing Home Services, Inc.</u>	100.00%	2,906	2,906	7
8	V	25 <u>See Schedule VIII</u>		<u>Bravo Nursing Home Services, Inc.</u>	100.00%	2,658	2,658	8
9	V	26 <u>See Schedule VIII</u>		<u>Bravo Nursing Home Services, Inc.</u>	100.00%	1,485	1,485	9
10	V							10
11	V	10a <u>Therapy</u>	362,319	<u>Bravo Therapy Services, Inc.</u>		317,073	(45,246)	11
12	V							12
13	V							13
14	Total		\$ 500,319			\$ 426,623	\$ * (73,696)	14

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

Facility Name & ID Number Rosewood Care Ctr St. Charles

0049320

Report Period Beginning: 7/1/08

Ending: 6/30/09

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	6 Repairs & Maintenance	\$ 120,808	Bravo Senior Living Services, Inc.		\$ 75,693	\$ (45,115)
16	V	21 Clerical & Office Expenses		Bravo Senior Living Services, Inc.		1,582	1,582
17	V	22 Payroll Taxes & Emp Ben.		Bravo Senior Living Services, Inc.		7,382	7,382
18	V	24 Travel & Seminar		Bravo Senior Living Services, Inc.		3,900	3,900
19	V	25 Other Admin Staff Transportation		Bravo Senior Living Services, Inc.		6,401	6,401
20	V	26 Insurance		Bravo Senior Living Services, Inc.		1,450	1,450
21	V	30 Depreciation		Bravo Senior Living Services, Inc.		4,152	4,152
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 120,808			\$ 100,560	\$ * (20,248)

* 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: 7/1/08 Ending: 6/30/09

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Michael Brady	President, Bravo	Administrative	0.00	151,725	4	6.49	Salary	\$ 10,525	21, 8	1
2		N.H. Services, Inc.									2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 10,525		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:

7/1/08

Ending: 6/30/09

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization Bravo Nursing Home Services
 Street Address 11701 Borman Drive, Suite 315
 City / State / Zip Code St. Louis, MO 63146
 Phone Number (314) 994-9070
 Fax Number (314) 994-9912

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Total Cost	15	\$ 43	\$	5,952,612	\$ 3	1
2	19	Professional Services	Total Cost	15	13,516		5,952,612	877	2
3	20	Dues & Subscriptions	Total Cost	15	304		5,952,612	20	3
4	21	Salaries - other	Total Cost	15	1,339,568	1,339,568	5,952,612	86,897	4
5	21	Taxes, Licenses & Ofc Supp	Total Cost	15	1,114		5,952,612	72	5
6	21	Telephone	Total Cost	15	10,071		5,952,612	653	6
7	22	Payroll Taxes	Total Cost	15	100,000		5,952,612	6,487	7
8	22	Employee Benefits	Total Cost	15	115,495		5,952,612	7,492	8
9	24	Travel & Seminar	Total Cost	15	44,792		5,952,612	2,906	9
10	25	Other Admin Staff Transp	Total Cost	15	40,970		5,952,612	2,658	10
11	26	Insurance	Total Cost	15	22,897		5,952,612	1,485	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	TOTALS				\$ 1,688,770	\$ 1,339,568		\$ 109,550	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Rosewood Care Ctr St. Charles

0049320

Report Period Beginning:

7/1/08

Ending:

6/30/09

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		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	Schedule Not Applicable																	
2																		
3																		
4																		
5																		
Working Capital																		
6																		
7																		
8																		
9	TOTAL Facility Related					\$	\$		\$									
B. Non-Facility Related*																		
10																		
11																		
12																		
13																		
14	TOTAL Non-Facility Related					\$	\$		\$									
15	TOTALS (line 9+line14)					\$	\$		\$									

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

* 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:

7/1/08

Ending:

6/30/09

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. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
 List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr St. Charles

0049320

Report Period Beginning:

7/1/08

Ending:

6/30/09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4				\$	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Carpet Installation		2009	13,142	469	7	469		469
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total
SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37								37
		\$	\$		\$	\$	\$	
38	2008	118,482						38
39	2008	5,194						39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70		\$ 136,818	\$ 469		\$ 469	\$	\$ 469	70
TOTAL (lines 4 thru 69)								

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:

7/1/08

Ending:

6/30/09

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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 Depreciation (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	Bravo Senior Living Services	Various	Various	\$ 20,464	\$	\$ 4,152	\$ 4,152	4 Yrs	\$ 7,939	76
77										77
78										78
79										79
80	TOTALS			\$ 20,464	\$	\$ 4,152	\$ 4,152		\$ 7,939	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)	\$ 157,282	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 469	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 4,621	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,152	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 8,408	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section Not Applicable	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Section Not Applicable	\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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? YES NO

If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1999</u>	<u>109</u>	<u>12/1/07</u>	\$ <u>1,008,595</u>	<u>3</u>	<u>Unlimited</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		<u>109</u>		\$ <u>1,008,595</u>			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A.

None

N/A

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

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ Not Specified Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Section Not Applicable</u>		\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

10. Effective dates of current rental agreement:

Beginning 12/1/07

Ending 10/31/10

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

Fiscal Year Ending Annual Rent

12. 6/30/2010 \$ 998,400

13. 6/30/2011 \$ 332,800

14. _____ \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist	10a, 8	hrs	\$	10,604	\$	190,289	\$	10,604	\$	190,289					1
2	Licensed Speech and Language Development Therapist	10a, 8	hrs		917		21,542		917		21,542					2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	10a, 8	hrs		9,483		105,242		9,483		2,630		107,872			4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy	39, 2	# of prescripts								126,629		126,629			9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify): <u>lab, x-ray, enterals</u>	39, 2 & 39, 3					30,049				15,339		45,388			12
13	Other (specify): _____															13
14	TOTAL			\$	21,004	\$	347,122	\$	21,004	\$	144,598		491,720			14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **6/30/09** (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 10,345	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 65,000)	486,884		3
4	Supply Inventory (priced at Cost)	2,384		4
5	Short-Term Investments			5
6	Prepaid Insurance	27,092		6
7	Other Prepaid Expenses	2,880		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 529,585	\$	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	13,142		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(469)		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)	\$ 14,673	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 544,258	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 125,246	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	185,313		30
31	Accrued Taxes Payable (excluding real estate taxes)	15,844		31
32	Accrued Real Estate Taxes(Sch.IX-B)	151,693		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	Accrued Fees	26,848		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 504,944	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	1,069,994		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,069,994	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,574,938	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,030,680)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 544,258	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (131,640)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (131,640)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(899,040)	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)	\$ (899,040)	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)	\$ (1,030,680)	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: 7/1/08

Ending: 6/30/09

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,863,509	1
2	Discounts and Allowances for all Levels	(1,131,994)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,731,515	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	964,121	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 964,121	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	1,365	14
15	Telephone, Television and Radio	398	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)	\$ 5,663	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	492	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 492	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous (See Attached)	13,137	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 13,137	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,714,928	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,075,130	31
32	Health Care	3,032,729	32
33	General Administration	1,050,480	33
B. Capital Expense			
34	Ownership	1,223,934	34
C. Ancillary Expense			
35	Special Cost Centers	172,017	35
36	Provider Participation Fee	59,678	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,613,968	40
41	Income before Income Taxes (line 30 minus line 40)**	(899,040)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (899,040)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Rosewood Care Ctr St. Charles**

0049320

Report Period Beginning:

7/1/08

Ending:

6/30/09

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	1,960	2,065	\$ 75,461	\$ 36.54	1
2	Assistant Director of Nursing	1,706	1,797	60,482	33.66	2
3	Registered Nurses	20,994	22,118	693,404	31.35	3
4	Licensed Practical Nurses	8,643	9,106	248,210	27.26	4
5	CNAs & Orderlies	54,305	57,213	760,859	13.30	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,479	1,558	18,950	12.16	8
9	Activity Director					9
10	Activity Assistants	5,006	5,274	68,362	12.96	10
11	Social Service Workers	4,206	4,431	55,876	12.61	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,283	21,369	204,610	9.58	15
16	Dishwashers					16
17	Maintenance Workers	2,233	2,352	35,948	15.28	17
18	Housekeepers	14,507	15,284	127,087	8.32	18
19	Laundry	2,729	2,876	23,204	8.07	19
20	Administrator	1,287	1,356	39,101	28.84	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,069	14,823	201,238	13.58	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	6,267	6,603	86,018	13.03	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	159,674	168,225	\$ 2,698,810 *	\$ 16.04	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Contract	\$ 7,014	1, 3	35
36	Medical Director	Contract	4,125	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	6,715	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	980	11, 3	44
45	Social Service Consultant	Contract	1,256	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 20,090		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	6,594	\$ 372,242	10-3	50
51	Licensed Practical Nurses	493	21,423	10-3	51
52	Certified Nurse Assistants/Aides	1,833	45,775	10-3	52
53	TOTAL (lines 50 - 52)	8,920	\$ 439,440		53

SEE ACCOUNTANTS' COMPILATION REPORT

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								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
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 St. Charles

0049320

Report Period Beginning: 7/1/08

Ending: 6/30/09

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA \$6,496
- (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. \$ 53,379 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. \$ 59,678
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ No Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,365
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

Bravo Care of St. Charles, Inc.
Attachment to Schedule VII A
6/30/2009

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

Bravo Care of St. Charles, Inc.
Attachment to Schedule XVII Line 28
6/30/2009

OTHER REVENUE:

Vendor Discounts	381
Workers Comp Dividend	12,000
Miscellaneous	<u>756</u>
	<u><u>13,137</u></u>

BRAVO CARE OF ST. CHARLES, INC.
RECLASSIFICATIONS
MEDICAID COST REPORT
6/30/09

	<u>AMOUNT</u>	<u>LN #</u>
A		
TRAVEL & SEMINARS	(2,926)	24
DUES, SUBSCRIPTIONS & PROMOTIONS TO RECLASS IDPH LICENSE	2,926	20