

		FOR BHF USE			

LL2

Supportive Living Facility

**2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2010)**

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN SECTION 146.265 OF THE 89 IL ADMIN CODE. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS.

<p>I. Facility ID Number: 1000080</p> <p>Facility Name: <u>Foxes Grove Supportive Living Community</u></p> <p>Address: <u>395 Edwardsville Road</u> <u>Wood River</u> <u>62095</u> Number City Zip Code</p> <p>County: <u>Madison</u></p> <p>Telephone Number: (<u>618</u>) <u>259-0851</u> Fax # <u>(618) 259-0854</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>7/1/08</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Cindy A. Tefteller</u> Telephone Number: <u>(618) 465-7717</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/2009</u> to <u>6/30/2010</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) _____</td> <td></td> </tr> <tr> <td></td> <td>(Title) _____</td> <td></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) <u>See Accountant's Compilation Report</u></td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) <u>Cindy A. Tefteller</u></td> <td></td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C. 233 E. Center Drive, Alton, IL 62002</u></td> <td></td> </tr> <tr> <td></td> <td>(Telephone) <u>(618) 465-7717</u> Fax <u>(618) 465-7710</u></td> <td></td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE IL DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) _____			(Title) _____		Paid Preparer	(Signed) <u>See Accountant's Compilation Report</u>	(Date) _____		(Print Name and Title) <u>Cindy A. Tefteller</u>			(Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C. 233 E. Center Drive, Alton, IL 62002</u>			(Telephone) <u>(618) 465-7717</u> Fax <u>(618) 465-7710</u>	
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Facility Name Foxes Grove Supportive Living Community

Report Period Beginning: 7/1/2009 Ending: 6/30/2010

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days

Date of change in certified units / /

	1	2	3	4	
	Units at Beginning of Report Period	Type of Apartment	Units at End of Report Period	Unit Days During Report Period	
1	83	Single Unit Apartment	83	30,295	1
2	11	Double Unit Apartment	11	4,015	2
3		Other		4,015	3
4	94	TOTALS	94	38,325	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 5 Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	13,553	17,651		31,204	5
6	Double Unit					6
7	Other					7
8	TOTALS	13,553	17,651		31,204	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 81.42%

D. Indicate the number of paid bed-hold days the SLF had during this year
None Also, indicate the number of unpaid bed-hold days the SLF had during this year. None **(Do not include bed-hold days in Section B.)**

E. Does page 3 include expenses for services or investments not directly related to SLF services?

YES NO

F. Does the BALANCE SHEET reflect any non-SLF assets?

YES NO

G. List all services provided by your facility for non-residents.

(E.g., day care, "meals on wheels", outpatient therapy)

None

H. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/2010 Fiscal Year: 6/30/2010

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

J. Does the facility have any Illinois Housing Development Authority Loans outstanding? No If yes, did the facility make all of the

required payments of interest and principle? N/A

If no, explain. N/A

K. Does the facility have any loans from the Federal Home Loan Bank outstanding? No If yes, did the facility make all of the

required payments of interest and principle? N/A

If no, explain. N/A

L. Does the facility have any loans from the IL Dept of Commerce and Economic Opportunity outstanding? No If yes, did the facility

make all of the required payments of interest and principle? N/A

If no, explain. N/A

Facility Name: Foxes Grove Supportive Living Community

Report Period Beginning:

7/1/2009

Ending: 6/30/2010

IV. COST CENTER EXPENSES (please round to the nearest dollar)

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments 5	Adjusted Total 6	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
A. General Services								
1	Dietary and Food Purchase	204,494	192,232	1,344	398,070		398,070	1
2	Housekeeping, Laundry and Maintenance	120,211	36,174	135,199	291,584	(13,661)	277,923	2
3	Heat and Other Utilities			136,032	136,032		136,032	3
4	Other (specify): Garbage Collection			5,541	5,541		5,541	4
5	TOTAL General Services	324,705	228,406	278,116	831,227	(13,661)	817,566	5
B. Health Care and Programs								
6	Health Care/ Personal Care	378,198	3,093		381,291		381,291	6
7	Activities and Social Services		12,708	1,158	13,866		13,866	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	378,198	15,801	1,158	395,157		395,157	9
C. General Administration								
10	Administrative and Clerical	143,169	7,114	130,252	280,535	16,499	297,034	10
11	Marketing Materials, Promotions and Advertising			5,138	5,138		5,138	11
12	Employee Benefits and Payroll Taxes			117,457	117,457	6,689	124,146	12
13	Insurance-Property, Liability and Malpractice			9,362	9,362	602	9,964	13
14	Other (specify):							14
15	TOTAL General Administration	143,169	7,114	262,209	412,492	23,790	436,282	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	846,072	251,321	541,483	1,638,876	10,129	1,649,005	16
Capital Expenses								
D. Ownership								
17	Depreciation			6,665	6,665	981	7,646	17
18	Interest			164	164		164	18
19	Real Estate Taxes			137,807	137,807		137,807	19
20	Rent -- Facility and Grounds			862,799	862,799	24	862,823	20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			1,007,435	1,007,435	1,005	1,008,440	23
24	GRAND TOTAL (Sum of lines 16 and 23)	846,072	251,321	1,548,918	2,646,311	11,134	2,657,445	24

Facility Name: Foxes Grove Supportive Living Community

Report Period Beginning: 7/1/2009

Ending:

6/30/2010

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 29.04	1
2	Licensed Practical Nurses	3	19.08	2
3	Certified Nurse Assistants	10	9.64	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook	1	13.69	6
7	Cook Helpers/Assistants	10	8.45	7
8	Dishwashers			8
9	Maintenance Workers	3	9.18	9
10	Housekeepers	3	8.84	10
11	Laundry			11
12	Managers			12
13	Other Administrative	1	28.96	13
14	Clerical	4	10.96	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	36	\$ 11.30	17

VI. (A) STATEMENT OF COMPENSATION AND OTHER PAYMENTS TO OWNERS, RELATIVES AND MEMBERS OF THE BOARD OF DIRECTORS.

	NAME and FUNCTION	Ownership Interest	Average Hours Per Work Week Devoted to this Business	Amount of Compensation for this Reporting Period	
1	Michael Brady Administrative	0	2	\$ 4,382	1
2					2
3					3
4					4
5					5
Total				\$ 4382	6

VI. (B) Management fees paid to unrelated parties

	Section Not Applicable	Amount of Fee	
1	Section Not Applicable	\$	1
2			2
Total		\$	3

VII. RELATED ORGANIZATIONS

A. Enter below the names of all related organizations. Attach an additional schedule if necessary.

RELATED SLF's & HEALTH CARE BUSINESSES

Name	1	City	2
See Attached			

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5
See Attached					

B. Does your facility receive services from a parent organization or home office; the costs for which were not included on page 3? YES NO

Name of related entity: See Attached Schedules If yes, what is the value of those services? \$ See Attached Schedules
(Please attach a separate schedule itemizing those services.)

C. Does page 3 include any costs derived from transactions (including rent) with related parties? YES NO

If so, please attach a separate schedule detailing the nature of those services, their costs as they appear on your books and the underlying cost to the related party (i.e., not including markup).

Facility Name: Foxes Grove Supportive Living Community

Report Period Beginning:

7/1/2009

Ending:

6/30/2010

VIII. OWNERSHIP COSTS

A. Purchase price of land _____ Year land was acquired _____

B. Building Depreciation -- Including Fixed Equipment. Round all numbers to the nearest dollar.

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

	1 Units*	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	
1					\$	\$		\$	\$	\$	1
2											2
3											3
4											4
5											5
Improvement Type											
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$	\$		\$	\$	\$	17

C. Equipment Depreciation -- Including Transportation.

	Type	1 Cost	2 Current Book Depreciation	3 Straight Line Depreciation	4 Adjustments	5 Life in Years	6 Accumulated Depreciation	
18	Movable Equipment	\$	\$	\$	\$		\$	18
19	Vehicles	30,649	6,665	7,646	981	4 Yrs	13,920	19
20	TOTAL (lines 18 and 19)	\$ 30,649	\$ 6,665	\$ 7,646	981		\$ 13,920	20

D. Depreciable Non-Care Assets Included in General Ledger.

	1 Description and Year Acquired	2 Cost	3 Current Book Depreciation	4 Accumulated Depreciation	
21	Section Not Applicable	\$	\$	\$	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	\$	\$	\$	24

Facility Name: **Foxes Grove Supportive Living Community**

Report Period Beginning: **7/1/2009**

Ending: **5/30/2010**

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: Wood River Real Estate Holding Company

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO

		1	2	3	4	5	6	
		Year Constructed	Number of Units	Date of Lease	Rental Amount	Total Yrs. of Lease	Total Years Renewal Option*	
3	Original Building	1987	46	7/1/08	\$ 862,799	2	Unlimited	3
4	Additions	1990	48	/ /				4
5				/ /				5
6	Related Party Allocation			/ /	24			6
7	TOTAL		94		\$ 862,823			7

8. Is movable equipment rental included in building rental? YES NO

YES NO

9. Rental amount for movable equipment \$ Not Specified

10. If the facility rents any vehicles which are used for care-related purposes, please attach a schedule detailing the model year and make, the rental expense for this period and the use of the vehicle.

X. INTEREST EXPENSE

	1	Name of Lender	2		3	4	6		7	8	9
			Related**				Purpose of Loan	Date of Note			
			YES	NO			Original	Balance			
		A. Directly Facility Related									
		Long-Term									
1		Schedule Not Applicable				/ /	\$	\$	/ /		\$
2						/ /			/ /		
3						/ /			/ /		
		Working Capital									
4						/ /			/ /		
5						/ /			/ /		
6						/ /			/ /		
7		TOTAL Facility Related					\$	\$			\$
		B. Non-Facility Related									
8						/ /			/ /		
9						/ /			/ /		
10		TOTALS (lines 7, 8 and 9)					\$	\$			\$

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

** If there is any overlap in ownership between the facility and the lender, this must be indicated in column 2.

Facility Name: **Foxes Grove Supportive Living Community**Report Period Beginning: **7/1/2009**

Ending:

6/30/2010**XI. BALANCE SHEET - Unrestricted Operating Fund.**As of **6/30/2010**

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 9,281	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>5,000</u>)	207,344		3
4	Supply Inventory (priced at <u>Cost</u>)	5,776		4
5	Short-Term Investments			5
6	Prepaid Insurance	3,090		6
7	Other Prepaid Expenses	28,343		7
8	Accounts Receivable (owners or related parties)	158,035		8
9	Other(specify): <u>Deposits</u>	234		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 412,103	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	26,660		16
17	Accumulated Depreciation (book methods)	(11,812)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Deposits</u>	500		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 15,348	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 427,451	\$	25

*(See instructions.)

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 28,877	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	62,000		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	66,311		30
31	Accrued Taxes Payable	176,881		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	<u>Accrued Expenses</u>	17,545		35
36	<u>Accrued Rent</u>	5,500		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 357,114	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable			39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42				42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 357,114	\$	45
46	TOTAL EQUITY	\$ 70,337	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 427,451	\$	47

Facility Name: Foxes Grove Supportive Living Community

Report Period Beginning: 7/1/2009

Ending:

6/30/2010

XII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this Schedule to Schedule IV.)

		1	
Revenue		Amount	
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 2,672,368	1
2	Discounts and Allowances	(4,337)	2
SUBTOTAL Resident Care			
3	(line 1 minus line 2)	\$ 2,668,031	3
B. Other Operating Revenue			
4	Special Services		4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop	165	7
8	Barber and Beauty Care	2,400	8
9	Non-Resident Meals	4,810	9
10	Laundry		10
SUBTOTAL OTHER OPERATING REVENUE			
11	(sum of lines 4 thru 10)	\$ 7,375	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	7,427	13
SUBTOTAL Non-Operating Revenue			
14	(sum of lines 12 and 13)	\$ 7,427	14
D. Other Revenue (specify):			
15	Miscellaneous	5,155	15
16	Application Fee Income	2,850	16
SUBTOTAL Other Revenue			
17	(sum of lines 15 and 16)	\$ 8,005	17
TOTAL REVENUE			
18	(sum of lines 3, 11, 14 and 17)	\$ 2,690,838	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	831,227	19
20	Health Care/ Personal Care	395,157	20
21	General Administration	412,492	21
B. Capital Expense			
22	Ownership	1,007,435	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
TOTAL EXPENSES			
28	(sum of lines 19 thru 27)	\$ 2,646,311	28
Income Before Income Taxes			
29	(line 18 minus line 28)	\$ 44,527	29
Income Taxes			
30		\$	30
NET INCOME OR LOSS FOR THE YEAR			
31	(line 29 minus line 30)	\$ 44,527	31

Foxes Grove Supportive Living Community
Attachment to Schedule VII
6/30/2010

Related Health Care Businesses: City:

Bravo Care of Alton, Inc. Alton, IL
Bravo Care of East Peoria, Inc. East Peoria, IL
Bravo Care of Edwardsville, Inc. Edwardsville, IL
Bravo Care of Elgin, Inc. Elgin, IL
Bravo Care of Galesburg, Inc. Galesburg, IL
Bravo Care of Inverness, Inc. Inverness, IL
Bravo Care of Joliet, Inc. Joliet, IL
Bravo Care of Moline, Inc. Moline, IL
Bravo Care of Northbrook, Inc. Northbrook, IL
Bravo Care of Peoria, Inc. Peoria, IL
Bravo Care of Rockford, Inc. Rockford, IL
Bravo Care of St. Charles, Inc. St. Charles, IL
Bravo Care of St. Louis, Inc. St. Louis, MO

Other Related Businesses: Type of Business:

Bravo Nursing Home Services, Inc. Management Co.
Bravo Holding Company, Inc. Holding Co.
Bravo Senior Living Services, Inc. Building Services Co.
Bravo Therapy Services, Inc. Therapy Co.
Bravo Team Health, Inc. Human Resources Co.

Senior Living Services
Construction and Building Services Allocation
6/30/2010

	Per SLS T/B Base Fees	577,393.86			74,451.33	64,306.28	10,749.13	43,416.30	1,056.00
		Pooled Line 2	Direct Line 2	Total Line 2	Pooled Line 10	Pooled Line 12	Pooled Line 13	Pooled Line 17	Pooled Line 20
Alton	73,271.17	35,210.22	1,182.94	36,393.16	4,540.14	3,921.48	655.50	2,647.58	64.40
East Peoria	100,699.96	48,391.04	1,213.45	49,604.49	6,239.72	5,389.48	900.88	3,638.69	88.50
Edwardsville	80,305.43	38,590.51	1,020.35	39,610.86	4,976.01	4,297.95	718.43	2,901.76	70.58
Elgin	103,072.13	49,530.97	2,877.26	52,408.23	6,386.71	5,516.43	922.10	3,724.41	90.59
Galesburg	92,393.04	44,399.17	2,327.68	46,726.85	5,725.00	4,944.89	826.56	3,338.53	81.20
Inverness	97,638.87	46,920.04	1,518.02	48,438.06	6,050.04	5,225.64	873.49	3,528.08	85.81
Joliet	81,488.24	39,158.91	4,610.48	43,769.39	5,049.30	4,361.25	729.01	2,944.50	71.62
Moline	85,134.38	40,911.05	1,988.56	42,899.61	5,275.23	4,556.40	761.63	3,076.25	74.82
Northbrook	82,675.49	39,729.44	3,322.90	43,052.34	5,122.86	4,424.80	739.63	2,987.40	72.66
Peoria	58,302.18	28,016.92	1,108.79	29,125.71	3,612.61	3,120.34	521.58	2,106.69	51.24
Rockford	68,405.60	32,872.09	1,614.47	34,486.56	4,238.65	3,661.07	611.97	2,471.77	60.12
St. Charles	110,314.87	53,011.45	5,863.78	58,875.23	6,835.50	5,904.06	986.89	3,986.12	96.95
St. Louis	69,207.11	33,257.25	740.88	33,998.13	4,288.31	3,703.97	619.14	2,500.73	60.82
Swansea	71,465.75	34,342.63	3,306.26	37,648.89	4,428.27	3,824.85	639.34	2,582.34	62.81
Wood River	27,161.11	13,052.18	446.56	13,498.74	1,682.99	1,453.66	242.99	981.44	23.87
MAS	-	-	-	-	-	-	-	-	-
	1,201,535.33	577,393.87	33,142.38	610,536.25	74,451.34	64,306.27	10,749.14	43,416.29	1,055.99

Bravo Holding Company
Related Party Allocation
6/30/2010

	Total Facility Costs	28,117.01	
		Pooled Line 10	Pooled Line 13
Alton	7,599,159	2,296.78	701.10
East Peoria	5,174,932	1,564.08	477.44
Edwardsville	6,493,124	1,962.49	599.05
Elgin	7,846,283	2,371.48	723.90
Galesburg	5,344,130	1,615.22	493.05
Inverness	7,412,801	2,240.46	683.90
Joliet	7,362,165	2,225.16	679.23
Moline	5,041,709	1,523.82	465.15
Northbrook	7,872,094	2,379.27	726.28
Peoria	6,060,622	1,831.78	559.15
Rockford	5,928,839	1,791.95	546.99
St. Charles	5,816,236	1,757.89	536.60
St. Louis	5,253,898	1,587.95	484.72
Swansea	7,226,928	2,184.29	666.75
Wood River	2,595,150	784.37	239.43
	93,028,070	28,116.99	8,582.74

Bravo Care Centers
Home Office Cost Allocations for Medicaid
6/30/2010

Facility	BRAVO Alton	BRAVO East Peoria	BRAVO Edwardsville	BRAVO Elgin	BRAVO Galesburg	BRAVO Inverness	BRAVO Joliet	BRAVO Moline	BRAVO Northbrook	BRAVO Peoria	BRAVO Rockford	BRAVO St. Charles	BRAVO St. Louis	RCC Swansea	BRAVO Wood River	Total	
Facility Total Cost	7,599,159	5,174,932	6,493,124	7,846,283	5,344,130	7,412,801	7,362,165	5,041,709	7,872,094	6,060,622	5,928,839	5,816,236	5,253,898	7,226,928	2,595,150	93,028,070	
Pooled Costs:																	
6 Maintenance	32	3	2	2	3	2	3	3	2	3	2	2	2	2	1	34	
19 Professional Services	3,777	309	210	264	319	217	301	299	205	320	246	241	236	213	293	3,778	
20 Dues & Subscriptions	225	18	13	16	19	13	18	18	12	19	15	14	14	13	17	225	
21 Salaries - Other	1,269,110	103,669	70,598	88,581	107,041	72,906	101,127	100,436	68,780	107,393	82,680	80,883	79,346	71,675	98,591	1,269,110	
21 Taxes, Licenses & Ofc Sup	1,606	131	89	112	135	92	128	127	87	136	105	102	100	91	125	1,605	
21 Telephone	9,847	804	548	687	831	566	785	779	534	833	642	628	616	556	765	9,849	
22 Payroll Taxes	93,248	7,617	5,187	6,508	7,865	5,357	7,430	7,380	5,054	7,891	6,075	5,943	5,830	5,266	7,244	93,248	
22 Employee Benefits	94,412	7,712	5,252	6,590	7,963	5,424	7,523	7,472	5,117	7,989	6,151	6,017	5,903	5,332	7,334	94,413	
24 Travel & Seminar	46,571	3,804	2,591	3,251	3,928	2,675	3,711	3,686	2,524	3,941	3,034	2,968	2,912	2,630	3,618	46,572	
25 Other Admin Staff Transp	35,723	2,918	1,987	2,493	3,013	2,052	2,847	2,827	1,936	3,023	2,327	2,277	2,233	2,018	2,775	35,723	
26 Insurance	4,291	351	239	300	362	247	342	340	233	363	280	273	268	242	333	4,293	
Total Pooled Costs	1,558,842	127,336	86,716	108,804	131,479	89,551	124,215	123,367	84,484	131,911	101,557	99,348	97,460	88,038	121,097	43,487	1,558,850
Total Direct Costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Facility Home Office Costs	1,558,842	127,336	86,716	108,804	131,479	89,551	124,215	123,367	84,484	131,911	101,557	99,348	97,460	88,038	121,097	43,487	1,558,850
21 Grand Total	1,280,563	104,604	71,235	89,380	108,007	73,564	102,040	101,342	69,401	108,362	83,427	81,613	80,062	72,322	99,481	35,724	1,280,564
22 Grand Total	187,660	15,329	10,439	13,098	15,828	10,781	14,953	14,852	10,171	15,880	12,226	11,960	11,733	10,598	14,578	5,235	187,661

FOXES GROVE SUPPORTIVE LIVING COMMUNITY
ADJUSTMENTS
6/30/10

DESCRIPTION	SCHED V LINE #	INCREASE (DECREASE)
PROFESSIONAL SERVICES TO ELIMINATE NON-ALLOWABLE EXPENSES	10	(99)
RELATED PARTY MANAGEMENT FEES	10	(24,000)
MAINTENANCE COSTS	2	1
ADMINISTRATIVE AND CLERICAL COSTS	10	38,131
EMPLOYEE BENEFITS AND PAYROLL TAXES	12	5,235
INSURANCE TO REMOVE RELATED PARTY CHARGE FOR MANAGEMENT FEES AND ADD THE ACTUAL COST OF SERVICES	13	120
RELATED PARTY BUILDING SERVICE FEES	2	(27,161)
BUILDING SERVICE COSTS	2	13,499
ADMINISTRATIVE AND GENERAL COSTS	10	1,683
EMPLOYEE BENEFITS AND PAYROLL TAXES	12	1,454
INSURANCE	13	243
DEPRECIATION	17	981
RENT TO REMOVE RELATED PARTY BUILDING SERVICES CHARGE AND ADD THE ACTUAL COST OF SERVICES	20	24
ADMINISTRATIVE AND GENERAL COSTS	10	784
INSURANCE TO ADD ACTUAL COSTS OF RELATED PARTY SERVICES	13	239
TOTAL SCHEDULE VI LINE 30		<u>11,134</u>