



Facility Name & ID Number Rosewood Care Center of Alton

# 0049288 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	180	Skilled (SNF)	180	65,880	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	180	TOTALS	180	65,880	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF			6,721	6,721	8
9	SNF/PED					9
10	ICF	9,933	19,381		29,314	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,933	19,381	6,721	36,035	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.70%

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 12/01/07

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 12/01/07 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 48 and days of care provided 6,721

Medicare Intermediary Pinnacle Business Solutions, Inc.

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

Rosewood Care Center of Alton

# 0049288

Report Period Beginning:

7/1/2011

Ending:

6/30/2012

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 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
	<b>A. General Services</b>										
1	Dietary	241,411	24,141	8,009	273,561		273,561		273,561		1
2	Food Purchase		220,393		220,393		220,393	(1,640)	218,753		2
3	Housekeeping	217,673	53,069		270,742		270,742		270,742		3
4	Laundry	70,625	16,277		86,902		86,902		86,902		4
5	Heat and Other Utilities			154,819	154,819		154,819		154,819		5
6	Maintenance	32,643	8,733	268,095	309,471		309,471	(69,689)	239,782		6
7	Other (specify):* <b>Waste Disposal</b>			8,386	8,386		8,386		8,386		7
8	<b>TOTAL General Services</b>	562,352	322,613	439,309	1,324,274		1,324,274	(71,329)	1,252,945		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			11,113	11,113		11,113		11,113		9
10	Nursing and Medical Records	2,757,809	216,515	69,659	3,043,983		3,043,983	39,439	3,083,422		10
10a	Therapy	70,108	787		70,895		70,895	4,987	75,882		10a
11	Activities	81,848	4,377	2,400	88,625		88,625		88,625		11
12	Social Services	51,773		2,400	54,173		54,173		54,173		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,961,538	221,679	85,572	3,268,789		3,268,789	44,426	3,313,215		16
	<b>C. General Administration</b>										
17	Administrative	67,295		138,000	205,295		205,295	(123,855)	81,440		17
18	Directors Fees										18
19	Professional Services			346,581	346,581		346,581	(42,435)	304,146		19
20	Dues, Fees, Subscriptions & Promotions			23,561	23,561	2,715	26,276	(9,604)	16,672		20
21	Clerical & General Office Expenses	161,491	24,421	15,536	201,448		201,448	(25,410)	176,038		21
22	Employee Benefits & Payroll Taxes			499,251	499,251		499,251	27,094	526,345		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,008	4,008	(2,715)	1,293	5,606	6,899		24
25	Other Admin. Staff Transportation			16,527	16,527		16,527	(5,799)	10,728		25
26	Insurance-Prop.Liab.Malpractice			10,578	10,578		10,578	1,257	11,835		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	228,786	24,421	1,054,042	1,307,249		1,307,249	(173,146)	1,134,103		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,752,676	568,713	1,578,923	5,900,312		5,900,312	(200,049)	5,700,263		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 Center of Alton

#0049288

Report Period Beginning:

7/1/2011

Ending:

6/30/2012

## 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	
	<b>D. Ownership</b>											
30	Depreciation			102	102		102	1,784	1,886			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			55,326	55,326		55,326	(35,152)	20,174			32
33	Real Estate Taxes					140,587	140,587		140,587			33
34	Rent-Facility & Grounds			1,253,077	1,253,077	(140,587)	1,112,490		1,112,490			34
35	Rent-Equipment & Vehicles			26,704	26,704		26,704		26,704			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,335,209	1,335,209		1,335,209	(33,368)	1,301,841			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		257,321	780,559	1,037,880		1,037,880		1,037,880			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			272,064	272,064		272,064		272,064			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		257,321	1,052,623	1,309,944		1,309,944		1,309,944			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,752,676	826,034	3,966,755	8,545,465		8,545,465	(233,417)	8,312,048			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

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(159)	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	(2,319)	32		10
11	Discounts, Allowances, Rebates & Refunds	(894)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(587)	2		13
14	Non-Care Related Interest	(55,326)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,399)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,493)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,058)	20		28
29	Other-Attach Schedule	(92,867)	Var.		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (160,102)		\$	30

<b>BHF USE ONLY</b>					
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	2	
		<b>Amount</b>	<b>Reference</b>	
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)	(73,315)	Var.	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (73,315)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (233,417)		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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Care Center of Alton

ID# 0049288

Report Period Beginning: 7/1/2011

Ending: 6/30/2012

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Eliminate Marketing Salary	\$ (68,578)	21	1
2	Eliminate Marketing Payroll Taxes	(5,246)	22	2
3	Eliminate Marketing Mileage	(14,753)	25	3
4	Eliminate Lobbying & PAC Dues	(4,290)	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
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	<b>Total</b>		(92,867)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Center of Alton# 0049288

Report Period Beginning:

7/1/2011

Ending:

6/30/2012

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	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	(1,640)	0	0	0	0	0	0	0	0	0	0	(1,640)	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	(69,689)	0	0	0	0	0	0	0	0	(69,689)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(1,640)</b>	<b>0</b>	<b>(69,689)</b>	<b>0</b>	<b>(71,329)</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	39,439	0	0	0	0	0	0	0	0	0	39,439	10
10a	Therapy	0	4,987	0	0	0	0	0	0	0	0	0	4,987	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>44,426</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44,426</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(123,855)	0	0	0	0	0	0	0	0	0	(123,855)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,399)	383	(40,419)	0	0	0	0	0	0	0	0	(42,435)	19
20	Fees, Subscriptions & Promotions	(9,841)	19	218	0	0	0	0	0	0	0	0	(9,604)	20
21	Clerical & General Office Expenses	(68,578)	41,389	1,779	0	0	0	0	0	0	0	0	(25,410)	21
22	Employee Benefits & Payroll Taxes	(5,246)	22,558	9,782	0	0	0	0	0	0	0	0	27,094	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	2,115	3,491	0	0	0	0	0	0	0	0	5,606	24
25	Other Admin. Staff Transportation	(14,753)	3,143	5,811	0	0	0	0	0	0	0	0	(5,799)	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,257	0	0	0	0	0	0	0	0	1,257	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(100,817)</b>	<b>(54,248)</b>	<b>(18,081)</b>	<b>0</b>	<b>(173,146)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(102,457)</b>	<b>(9,822)</b>	<b>(87,770)</b>	<b>0</b>	<b>(200,049)</b>	<b>29</b>							

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Center of Alton# 0049288

Report Period Beginning:

7/1/2011

Ending:

6/30/2012

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

	Capital Expense	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)	
	<b>D. Ownership</b>													
30	Depreciation	0	0	1,784	0	0	0	0	0	0	0	0	1,784	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(57,645)	0	22,493	0	0	0	0	0	0	0	0	(35,152)	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	<b>TOTAL Ownership</b>	<b>(57,645)</b>	<b>0</b>	<b>24,277</b>	<b>0</b>	<b>(33,368)</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(160,102)</b>	<b>(9,822)</b>	<b>(63,493)</b>	<b>0</b>	<b>(233,417)</b>	<b>45</b>							

**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
<u>Bravo Services, L.L.C.</u>	<u>100</u>	<u>Bravo Care of East Peoria, Inc.</u>	<u>East Peoria, IL</u>	<u>Bravo Care of Wood River, Inc.</u>	<u>Wood River, IL</u>	<u>Supportive Living Facility</u>
		<u>Bravo Care of Edwardsville, Inc.</u>	<u>Edwardsville, IL</u>	<u>Bravo Nursing Home Services, Inc.</u>	<u>St. Louis, MO</u>	<u>Management Co.</u>
		<u>Bravo Care of Elgin, Inc.</u>	<u>Elgin, IL</u>	<u>Bravo Holding Company, Inc.</u>	<u>St. Louis, MO</u>	<u>Holding Co.</u>
		<u>Bravo Care of Galesburg, Inc.</u>	<u>Galesburg, IL</u>			
		<u>Bravo Care of Inverness, Inc.</u>	<u>Inverness, IL</u>			
		<u>Bravo Care of Joliet, Inc.</u>	<u>Joliet, IL</u>			
		<u>Bravo Care of Moline, Inc.</u>	<u>Moline, IL</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 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	<u>10 See Schedule VIII</u>	\$	<u>Bravo Nursing Home Services, Inc.</u>	<u>100.00%</u>	<u>\$ 39,439</u>	<u>\$ 39,439</u>	<u>1</u>
2	V	<u>10a See Schedule VIII</u>		<u>Bravo Nursing Home Services, Inc.</u>	<u>100.00%</u>	<u>4,987</u>	<u>4,987</u>	<u>2</u>
3	V	<u>19 See Schedule VIII</u>		<u>Bravo Nursing Home Services, Inc.</u>	<u>100.00%</u>	<u>383</u>	<u>383</u>	<u>3</u>
4	V	<u>20 See Schedule VIII</u>		<u>Bravo Nursing Home Services, Inc.</u>	<u>100.00%</u>	<u>19</u>	<u>19</u>	<u>4</u>
5	V	<u>21 See Schedule VIII</u>		<u>Bravo Nursing Home Services, Inc.</u>	<u>100.00%</u>	<u>41,389</u>	<u>41,389</u>	<u>5</u>
6	V	<u>22 See Schedule VIII</u>		<u>Bravo Nursing Home Services, Inc.</u>	<u>100.00%</u>	<u>22,558</u>	<u>22,558</u>	<u>6</u>
7	V	<u>24 See Schedule VIII</u>		<u>Bravo Nursing Home Services, Inc.</u>	<u>100.00%</u>	<u>2,115</u>	<u>2,115</u>	<u>7</u>
8	V	<u>25 See Schedule VIII</u>		<u>Bravo Nursing Home Services, Inc.</u>	<u>100.00%</u>	<u>3,143</u>	<u>3,143</u>	<u>8</u>
9	V	<u>17 Management Fees/Officer Comp.</u>	<u>138,000</u>	<u>Bravo Nursing Home Services, Inc.</u>	<u>100.00%</u>	<u>14,145</u>	<u>(123,855)</u>	<u>9</u>
10	V							<u>10</u>
11	V							<u>11</u>
12	V							<u>12</u>
13	V							<u>13</u>
14	<b>Total</b>		<b>\$ 138,000</b>			<b>\$ 128,178</b>	<b>\$ * (9,822)</b>	<b>14</b>

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Alton# 0049288Report Period Beginning: 7/1/2011Ending: 6/30/2012

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  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	\$ 197,931	Senior Living Services, Inc.		\$ 128,242	\$ (69,689)
16	V	21 Clerical & Office Expenses		Senior Living Services, Inc.		976	976
17	V	22 Payroll Taxes & Emp Ben.		Senior Living Services, Inc.		4,831	4,831
18	V	24 Travel & Seminar		Senior Living Services, Inc.		2,289	2,289
19	V	25 Other Admin Staff Transportation		Senior Living Services, Inc.		4,770	4,770
20	V	26 Insurance		Senior Living Services, Inc.		976	976
21	V	30 Depreciation		Senior Living Services, Inc.		1,784	1,784
22	V						
23	V	19 Professional Services	80,817	Claims Administrative Services, LLC		36,332	(44,485)
24	V	20 Dues, Fees, & Subscriptions		Claims Administrative Services, LLC		101	101
25	V	21 Clerical & General Office Expenses		Claims Administrative Services, LLC		803	803
26	V	22 Payroll Taxes & Emp Ben.		Claims Administrative Services, LLC		4,951	4,951
27	V	24 Travel & Seminar		Claims Administrative Services, LLC		1,202	1,202
28	V	25 Other Admin Staff Transportation		Claims Administrative Services, LLC		1,041	1,041
29	V						
30	V	19 Professional Services		Bravo Holding Company		4,066	4,066
31	V	20 Dues, Fees, & Subscriptions		Bravo Holding Company		117	117
32	V	26 Insurance		Bravo Holding Company		281	281
33	V	32 Interest		Bravo Holding Company		22,493	22,493
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 278,748			\$ 215,255	\$ * (63,493)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Rosewood Care Center of Alton

# 0049288

Report Period Beginning:

7/1/2011

Ending:

6/30/2012

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Bravo Care of Northbrook, Inc.	Northbrook, IL	Senior Living		Building Services	1
2			Bravo Care of Peoria, Inc.	Peoria, IL	Services, Inc.	St. Louis, MO	Company	2
3			Bravo Care of Rockford, Inc.	Rockford, IL	Bravo Team		Human Resources	3
4			Bravo Care of St. Charles, Inc.	St. Charles, IL	Health, Inc.	St. Louis, MO	Company	4
5			Bravo Care of St. Louis, Inc.	St. Louis, MO				5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Alton # 0049288 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

## VII. RELATED PARTIES (continued)

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

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

	1 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	173,301	4.53	7.55	Salary	\$ 14,145	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	\$ 14,145		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Alton

# 0049288

Report Period Beginning:

7/1/2011

Ending: 7/30/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	Nursing & Medical Records	Total Cost	15	\$ 522,626	\$ 522,626	8,154,202	\$ 39,439	1
2	10a	Therapy	Total Cost	15	66,088	66,088	8,154,202	4,987	2
3	19	Professional Services	Total Cost	15	5,077		8,154,202	383	3
4	20	Dues and Subscriptions	Total Cost	15	252		8,154,202	19	4
5	21	Salaries-Other	Total Cost	15	535,914	535,914	8,154,202	40,442	5
6	21	Taxes, Liscenses, & Office Supplie	Total Cost	15	2,363		8,154,202	178	6
7	21	Telephone	Total Cost	15	10,197		8,154,202	769	7
8	22	Payroll Taxes	Total Cost	15	98,592		8,154,202	7,440	8
9	22	Employee Benefits	Total Cost	15	200,331		8,154,202	15,118	9
10	24	Travel & Seminar	Total Cost	15	28,031		8,154,202	2,115	10
11	25	Administrative Transportation	Total Cost	15	41,648		8,154,202	3,143	11
12	17	Salaries-Officers	Total Cost	15	187,446	187,446	8,154,202	14,145	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,698,565	\$ 1,312,074		\$ 128,178	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Rosewood Care Center of Alton

# 0049288

Report Period Beginning:

7/1/2011

Ending:

6/30/2012

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6		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
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1						\$	\$			\$	1							
2											2							
3											3							
4											4							
5											5							
<b>Working Capital</b>																		
6	Bravo Holding Co. Cost Allocation		Revolving Line of Credit		8/1/09		1,257,319	12/31/14	5.0000	22,493	6							
7											7							
8	Less: Interest Income Offset									(2,319)	8							
9	<b>TOTAL Facility Related</b>					\$	\$ 1,257,319			\$ 20,174	9							
<b>B. Non-Facility Related*</b>																		
10											10							
11											11							
12											12							
13											13							
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$	14							
15	<b>TOTALS (line 9+line14)</b>					\$	\$ 1,257,319			\$ 20,174	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.)



## 2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rosewood Care Center of Alton COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0049288

CONTACT PERSON REGARDING THIS REPORT Chuck Schmitz

TELEPHONE (314)994-9070 FAX #: (314)994-9912

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

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

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>23-2-02-31-00-000-049</u>	<u>Pebble Creek Outlot B</u>	\$ <u>140,586.96</u>	\$ <u>140,586.96</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>140,586.96</u></u>	\$ <u><u>140,586.96</u></u>

**B. Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

**PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.**

Facility Name & ID Number Rosewood Care Center of Alton

# 0049288 Report Period Beginning:

7/1/2011 Ending:

6/30/2012

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 58,176 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

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

None

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Alton

# 0049288

Report Period Beginning:

7/1/2011

Ending:

6/30/2012

**XI. OWNERSHIP COSTS (continued)**

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

1	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									
<b>Improvement Type**</b>									
9	Wallpaper & Chair Rail - Hallways		2012	4,070	102	10	102		102
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

Facility Name & ID Number Rosewood Care Center of Alton

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	<u>Building Imporvements Made by Lessor 12/1/07 - 6/30/12:</u>		\$			\$		\$	37
38	<u>Boiler</u>	2008	27,437						38
39	<u>Sidewalks</u>	2008	1,498						39
40	<u>Parking Lot Improvements</u>	2009	5,385						40
41	<u>Shower Tile</u>	2009	5,779						41
42	<u>Mcquay Heat Pumps</u>	2009	37,963						42
43	<u>Boiler</u>	2009	4,109						43
44	<u>Sidewalk</u>	2010	2,725						44
45	<u>Overlay Parking Lot</u>	2010	53,680						45
46	<u>Sprinkler System</u>	2010	7,996						46
47	<u>Flooring - Dining Room</u>	2010	8,255						47
48	<u>Painting &amp; Wallcovering - Dining Room</u>	2010	11,552						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	<b>TOTAL (lines 4 thru 69)</b>		\$ 170,449	\$ 102		\$ 102	\$	\$ 102	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ Section Not Applicable	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$	\$	\$	\$		\$	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Senior Living Services	Various	Various	\$ 16,184	\$	\$ 1,784	\$ 1,784	4	\$ 11,362	76
77										77
78										78
79										79
80	TOTALS			\$ 16,184	\$	\$ 1,784	\$ 1,784		\$ 11,362	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)	\$ 186,633	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 102	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 1,886	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,784	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 11,464	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: Alton Real Estate, Inc.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1989</u>	<u>120</u>	<u>03/01/11</u>	\$ <u>1,253,077</u>	<u>5</u>	<u>Unlimited</u>	3
4	Additions	<u>1998</u>	<u>60</u>	<u>03/01/11</u>				4
5	Real Estate Taxes				<u>(140,587)</u>			5
6								6
7	TOTAL		<u>180</u>		\$ <u>1,112,490</u>			7

10. Effective dates of current rental agreement:

Beginning 03/01/11

Ending 06/30/16

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

Fiscal Year Ending Annual Rent

12. 6/30/2013 \$ #####

13. 6/30/2014 \$ #####

14. 6/30/2015 \$ #####

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

This amount was calculated by dividing the total amount to be amortized

by the length of the lease N/A.

None

N/A

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

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

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Alton # 0049288 Report Period Beginning: 7/1/2011 Ending: 6/30/2012  
**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS** (See instructions.)

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

<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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		3		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost						
							hrs	\$				
1	Licensed Occupational Therapist		hrs	\$		\$						1
2	Licensed Speech and Language Development Therapist		hrs									2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	10a,8	hrs					787			787	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					257,321			257,321	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Physical, Occupational & Speech Therapy Other (specify): <u>Labs,X-Rays,Enterals</u>	39,3					780,559				780,559	13
14	<b>TOTAL</b>			\$		\$	780,559	\$	258,108	\$	1,038,667	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Alton# 0049288Report Period Beginning: 7/1/2011

Ending:

6/30/2012

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2012

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 9,511	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>43,304</u> )	829,285		3
4	Supply Inventory (priced at <u>Cost</u> )	4,091		4
5	Short-Term Investments			5
6	Prepaid Insurance	31,524		6
7	Other Prepaid Expenses	5,152		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 879,563	\$	10
	<b>B. Long-Term Assets</b>			
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	4,070		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(102)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Deposits</u>	2,700		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 6,668	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 886,231	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 256,450	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	286,173		30
31	Accrued Taxes Payable (excluding real estate taxes)	36,582		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Accrued Expenses</u>	199,646		36
37	<u>Accrued Rent</u>	105,000		37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 883,851	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	1,257,319		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 1,257,319	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 2,141,170	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (1,254,939)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 886,231	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (800,271)	1
2	Restatements (describe):		2
3	Prior year income tax adjustments after cost report	85,474	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (714,797)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(540,142)	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)	\$ (540,142)	17
<b>B. Transfers (Itemize):</b>			
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)	\$ (1,254,939)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 8,184,471	1
2	Discounts and Allowances for all Levels	(2,266,383)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 5,918,088</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,075,600	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 2,075,600</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
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	3,600	13
14	Non-Patient Meals	159	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 3,759</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	2,319	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 2,319</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See attached schedule</u>	5,557	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 5,557</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 8,005,323</b>	<b>30</b>

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,324,274	31
32	Health Care	3,268,789	32
33	General Administration	1,307,249	33
<b>B. Capital Expense</b>			
34	Ownership	1,335,209	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,037,880	35
36	Provider Participation Fee	272,064	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 8,545,465</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(540,142)</b>	<b>41</b>
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (540,142)</b>	<b>43</b>

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 1,076,947	44
45	Private Pay - Net Inpatient Revenue	3,264,084	45
46	Medicare - Net Inpatient Revenue	1,424,354	46
47	Other-(specify) <u>Managed Care - Net Inpatient Revenue</u>	152,703	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 5,918,088</b>	<b>49</b>

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

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

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

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

**SEE ACCOUNTANTS' COMPILATION REPORT**

Facility Name & ID Number Rosewood Care Center of Alton

# 0049288

Report Period Beginning: 7/1/2011

Ending: 6/30/2012

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,835	1,966	\$ 78,170	\$ 39.76	1
2	Assistant Director of Nursing	1,852	1,985	67,687	34.10	2
3	Registered Nurses	27,151	29,097	794,868	27.32	3
4	Licensed Practical Nurses	26,155	28,028	599,044	21.37	4
5	CNAs & Orderlies	98,781	105,858	1,123,978	10.62	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,660	3,922	70,108	17.88	8
9	Activity Director					9
10	Activity Assistants	6,005	6,435	81,848	12.72	10
11	Social Service Workers	3,949	4,232	51,773	12.23	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,002	22,507	241,411	10.73	15
16	Dishwashers					16
17	Maintenance Workers	1,996	2,139	32,643	15.26	17
18	Housekeepers	20,025	21,460	217,673	10.14	18
19	Laundry	7,414	7,945	70,625	8.89	19
20	Administrator	1,881	2,016	67,295	33.38	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,661	13,568	161,491	11.90	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,225	5,600	94,062	16.80	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	239,592	256,758	\$ 3,752,676 *	\$ 14.62	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	\$ 8,009	1,3	35
36	Medical Director	Contract	11,113	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	5,198	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Contract	2,400	11,3	44
45	Social Service Consultant	Contract	2,400	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 29,120		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	230	\$ 8,726	10-3	50
51	Licensed Practical Nurses	487	14,867	10-3	51
52	Certified Nurse Assistants/Aides	2,043	40,869	10-3	52
53	TOTAL (lines 50 - 52)	2,760	\$ 64,462		53

SEE ACCOUNTANTS' COMPILATION REPORT

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Kim Cornell	Administrator		\$ 67,295	Workers' Compensation Insurance	\$ 69,489	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	92,527	Advertising: Employee Recruitment	440	
				FICA Taxes	275,880	Health Care Worker Background Check	3,839	
				Employee Health Insurance	51,760	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Misc. Dues/Subscriptions/Fees	1,153	
				Employee Relations	1,562	Rosewood License Fee	3,000	
				Employee Uniforms	1,072	Promotional Advertising	5,551	
				Employee Physicals	1,050	Related Party Allocation	237	
				Related Party Allocations	32,340	IHCA Dues	6,013	
				Employee Drug Tests	665	Less: Public Relations Expense (		
						Non-allowable advertising	(4,493)	
						Yellow page advertising	(1,058)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
\$ 67,295				\$ 526,345		\$ 16,672		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description	Amount			Description	Line #	Amount	Description	Amount
Bravo Nursing Home Services	\$ 138,000			Section Not Applicable		\$	Out-of-State Travel	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
\$ 138,000				\$			\$ 6,899	
C. Professional Services								
Vendor/Payee	Type	Amount						
C.J. Schlosser & Company	Accountant/Consultant	\$ 4,145						
Midwest Administrative Services	Administrative/Bookkeeping	255,815						
Claims Administration Services, Inc.	Related Party Legal Fees	80,817						
Daniel Maher	Collections & Out-of-period	2,399						
Daniel Maher	Allowable Legal Fees	2,347						
Marsh, Inc.	Bond Renewal	100						
Gore Perry Reporting	Court Reporter	321						
Dr. Craig Harms	Witness Fee	20						
BJC Medical Group	Witness Fee	350						
May Reporting Service, P.C.	Deposition	217						
Mudge Legal Video, Inc.	Deposition	50						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
\$ 346,581				\$			\$ 6,899	

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Alton# 0049288Report Period Beginning: 7/1/2011Ending: 6/30/2012**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IHCA \$6,013
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? None
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 75,592 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES No NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 272,064  
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. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 159
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

**SEE ACCOUNTANTS' COMPILATION REPORT**

Bravo Care Center of Alton  
Attachment to Schedule XII E  
Other Revenue  
6/30/2012

Description		
28A	Vendor Discount	\$ 894
28B	Miscellaneous Income	3,352
28C	Vending Income	1,311
		<u>\$ 5,557</u>