

		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0049304

Facility Name: ROSEWOOD CARE CENTER OF MOLINE

Address: 7300 34th Avenue Moline 61265
Number City Zip Code

County: Rock Island

Telephone Number: (309)792-5942 Fax # (309)792-5975

HFS ID Number:

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

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2010 to 6/30/2011 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed)		(Date)	
	(Type or Print Name)			
	(Title)			
Paid Preparer	(Signed)	See Accountant's Compilation Report		
		(Date)		
	(Print Name and Title)	Cindy A. Tefteller		
	(Firm Name & Address)	C.J. Schlosser & Company, L.L.C. 233 E. Center Drive, Alton, IL 62002		
	(Telephone)	(618)465-7712 Fax # (618)465-7710		
MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630				

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROSEWOOD CARE CENTER OF MOLINE

0049304 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

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	<u>120</u>	Skilled (SNF)	<u>120</u>	<u>43,800</u>	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	<u>120</u>	TOTALS	<u>120</u>	<u>43,800</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>6,977</u>	<u>6,977</u>	8
9	SNF/PED					9
10	ICF	<u>8,925</u>	<u>9,987</u>		<u>18,912</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>8,925</u>	<u>9,987</u>	<u>6,977</u>	<u>25,889</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.11%

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

58

and days of care provided

6,977

Medicare Intermediary Pinnacle Business Solutions, Inc.

IV. ACCOUNTING BASIS

ACCRUAL

☒

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

☒

NO

☐

Tax Year: 6/30/11

Fiscal Year: 6/30/11

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **ROSEWOOD CARE CENTER OF MOLINE** # **0049304** Report Period Beginning: **7/1/2010** Ending: **6/30/2011**
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	211,846	17,010	9,604	238,460		238,460		238,460			1
2	Food Purchase		148,701		148,701		148,701	(8,099)	140,602			2
3	Housekeeping	140,577	29,782		170,359		170,359		170,359			3
4	Laundry	34,536	18,229		52,765		52,765		52,765			4
5	Heat and Other Utilities			105,156	105,156		105,156		105,156			5
6	Maintenance	30,219	5,509	172,893	208,621		208,621	(35,649)	172,972			6
7	Other (specify):* Garbage Collection			9,418	9,418		9,418		9,418			7
8	TOTAL General Services	417,178	219,231	297,071	933,480		933,480	(43,748)	889,732			8
	B. Health Care and Programs											
9	Medical Director			16,200	16,200		16,200		16,200			9
10	Nursing and Medical Records	1,723,149	211,821	30,920	1,965,890		1,965,890	28,466	1,994,356			10
10a	Therapy	64,302	4,426	653,167	721,895		721,895	11,289	733,184			10a
11	Activities	62,234	3,473	2,600	68,307		68,307		68,307			11
12	Social Services	41,876		2,600	44,476		44,476		44,476			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,891,561	219,720	705,487	2,816,768		2,816,768	39,755	2,856,523			16
	C. General Administration											
17	Administrative	70,868		138,000	208,868		208,868	(138,000)	70,868			17
18	Directors Fees											18
19	Professional Services			222,438	222,438		222,438	(330)	222,108			19
20	Dues, Fees, Subscriptions & Promotions			28,691	28,691	3,085	31,776	(6,189)	25,587			20
21	Clerical & General Office Expenses	147,321	23,247	14,878	185,446		185,446	(29,825)	155,621			21
22	Employee Benefits & Payroll Taxes			323,826	323,826		323,826	15,400	339,226			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,084	4,084	(3,085)	999	2,875	3,874			24
25	Other Admin. Staff Transportation			8,312	8,312		8,312	(2,336)	5,976			25
26	Insurance-Prop.Liab.Malpractice			90,033	90,033		90,033	1,187	91,220			26
27	Other (specify):*											27
28	TOTAL General Administration	218,189	23,247	830,262	1,071,698		1,071,698	(157,218)	914,480			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,526,928	462,198	1,832,820	4,821,946		4,821,946	(161,211)	4,660,735			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			363	363		363	1,686	2,049			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			48,474	48,474		48,474	(33,936)	14,538			32
33	Real Estate Taxes			120,864	120,864		120,864		120,864			33
34	Rent-Facility & Grounds			1,018,740	1,018,740		1,018,740		1,018,740			34
35	Rent-Equipment & Vehicles			23,263	23,263		23,263		23,263			35
36	Other (specify):*											36
37	TOTAL Ownership			1,211,704	1,211,704		1,211,704	(32,250)	1,179,454			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		232,181	41,221	273,402		273,402		273,402			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		232,181	106,921	339,102		339,102		339,102			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,526,928	694,379	3,151,445	6,372,752		6,372,752	(193,461)	6,179,291			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,915)	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	(2,010)	32		10
11	Discounts, Allowances, Rebates & Refunds	(900)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(284)	2		13
14	Non-Care Related Interest	(48,474)	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	(10)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,703)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,763)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,844)	20		28
29	Other-Attach Schedule	(79,128)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (146,031)		\$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(47,430)	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (47,430)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (193,461)		37

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

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

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

STATE OF ILLINOIS

ROSEWOOD CARE CENTER OF MOLINE

Report Period Beginning: ID# 0049304

Ending: 7/1/2010

6/30/2011

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Eliminate Marketing Salary	\$ (69,542)	21	1
2	Eliminate Marketing Mileage	(6,875)	25	2
3	Eliminate Lobbying & PAC Dues	(2,711)	20	3
4				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	Total	(79,128)		49

Summary A

6/30/2011

[illegible]

Summary B

Facility Name & ID Number	ROSEWOOD CARE CENTER OF MOLINE	#	0049304	Report Period Beginning:	7/1/2010	Ending:	6/30/2011
--------------------------------------	---------------------------------------	----------	----------------	---------------------------------	-----------------	----------------	------------------

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

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Bravo Services, L.L.C.	100	Bravo Care of Alton, Inc.	Alton, IL	Bravo Care of Wood River, Inc.	Wood River, IL	Supportive Living Facility
		Bravo Care of East Peoria, Inc.	East Peoria, IL	Bravo Nursing Home Services, Inc.		
		Bravo Care of Edwardsville, Inc.	Edwardsville, IL	Bravo Holding Company, Inc.		
		Bravo Care of Elgin, Inc.	Elgin, IL		St. Louis, MO	Management Co.
		Bravo Care of Galesburg, Inc.	Galesburg, IL			
		Bravo Care of Inverness, Inc.	Inverness, IL		St. Louis, MO	Holding Co.
		Bravo Care of Joliet, Inc.	Joliet, IL			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	See Schedule VIII	\$	Bravo Nursing Home Services, Inc.	100.00%	\$ 28,466	\$ 28,466	1
2	V	10a	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	6,382	6,382	2
3	V	19	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	259	259	3
4	V	20	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	44	44	4
5	V	21	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	39,304	39,304	5
6	V	22	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	12,988	12,988	6
7	V	24	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	1,660	1,660	7
8	V	25	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	2,219	2,219	8
9	V	26	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	360	360	9
10	V	17	Management Fees	138,000	Bravo Nursing Home Services, Inc.	100.00%		(138,000)	10
11	V								11
12	V								12
13	V	10a	Therapy	180,243	Bravo Therapy Services, Inc.		185,150	4,907	13
14	Total			\$ 318,243			\$ 276,832	\$ * (41,411)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ X

 YES

☐ NO

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

1		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	\$ 101,312	Senior Living Services, Inc.		\$ 65,663	\$ (35,649)	15
16	V	21	Clerical & Office Expenses		Senior Living Services, Inc.		423	423	16
17	V	22	Payroll Taxes & Emp Ben.		Senior Living Services, Inc.		2,412	2,412	17
18	V	24	Travel & Seminar		Senior Living Services, Inc.		1,215	1,215	18
19	V	25	Other Admin Staff Transportation		Senior Living Services, Inc.		2,320	2,320	19
20	V	26	Insurance		Senior Living Services, Inc.		551	551	20
21	V	30	Depreciation		Senior Living Services, Inc.		1,686	1,686	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	19	Professional Services		Bravo Holding Company		4,114	4,114	26
27	V	20	Dues & Subscriptions		Bravo Holding Company		85	85	27
28	V	26	Insurance		Bravo Holding Company		276	276	28
29	V	32	Interest		Bravo Holding Company		16,548	16,548	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 101,312			\$ 95,293	\$ * (6,019)	39

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	Bravo Therapy			1
2			Bravo Care of Peoria, Inc.	Peoria, IL	Services, Inc.	St. Louis, MO	Therapy Co.	2
3			Bravo Care of Rockford, Inc.	Rockford, IL	Senior Living		Building Services	3
4			Bravo Care of St. Charles, Inc.	St. Charles, IL	Services, Inc.	St. Louis, MO	Company	4
5			Bravo Care of St. Louis, Inc.	St. Louis, MO	Bravo Team		Human Resources	5
6					Health, Inc.	St. Louis, MO	Company	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

Facility Name & ID Number ROSEWOOD CARE CENTER OF MOLIN # 0049304 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

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	158,453	3.43	5.71	Salary	\$ 9,604	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	\$ 9,604		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 MOLINE # 0049304 Report Period Beginning: 7/1/2010 Ending: 7/30/2011

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		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	10	Nursing & Medical Records	Total Cost	107,176,506	15	\$ 498,142	\$	6,124,586	\$ 28,466	1
2	10a	Therapy	Total Cost	107,176,506	15	111,686		6,124,586	6,382	2
3	19	Professional Services	Total Cost	107,176,506	15	4,531		6,124,586	259	3
4	20	Dues & Subscriptions	Total Cost	107,176,506	15	777		6,124,586	44	4
5	21	Salaries-Other	Total Cost	107,176,506	15	674,650		6,124,586	38,553	5
6	21	Taxes, Licenses, & Office Sup	Total Cost	107,176,506	15	2,803		6,124,586	160	6
7	21	Telephone	Total Cost	107,176,506	15	10,343		6,124,586	591	7
8	22	Payroll Taxes	Total Cost	107,176,506	15	93,441		6,124,586	5,340	8
9	22	Employee Benefits	Total Cost	107,176,506	15	133,835		6,124,586	7,648	9
10	24	Travel & Seminar	Total Cost	107,176,506	15	29,046		6,124,586	1,660	10
11	25	Administrative Transportation	Total Cost	107,176,506	15	38,835		6,124,586	2,219	11
12	26	Insurance	Total Cost	107,176,506	15	6,296		6,124,586	360	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					\$ 1,604,385	\$		\$ 91,682	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Related Party Allocation-Bravo Holding Co.	Revolving Line of Credit				8/1/09			12/31/14	5.0000	16,548	6	
7												7	
8	Less: Interest Income Offset										(2,010)	8	
9	TOTAL Facility Related						\$	\$			\$ 14,538	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$	\$			\$ 14,538	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.)

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2010 report.				\$	61,858	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	60,907	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(951)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	121,815	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	120,864	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2006	129,191	8		
		2007	132,732	9		
		2008	136,160	10		
		2009	121,290	11		
		2010	121,815	12		
2010 Payment (\$60,907)						
Accrual = Remaining balance of 2010 tax bill (\$60,907) + 1/2 estimated 2011 tax bill (\$60,907)						

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>ROSEWOOD CARE CENTER OF MOLINE</u>	COUNTY	<u>Rock Island</u>
---------------	---------------------------------------	--------	--------------------

FACILITY IDPH LICENSE NUMBER 0049304

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 2010 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 2010.

(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>07-649-95-00</u>	<u>7300 34th Ave. parcel #13991</u>	\$ <u>101,472.84</u>	\$ <u>101,472.84</u>
2.	<u>07-649-94-00</u>	<u>Parcel #13990</u>	\$ <u>20,341.76</u>	\$ <u>20,341.76</u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
TOTALS			\$ <u>121,814.60</u>	\$ <u>121,814.60</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?

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,200

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?
If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

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					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Tile Repair			2008	2,540	363	7	363		1,240
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

*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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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 Building Improvements made by Lessor 12/1/07-6/30/11		\$	\$		\$	\$	\$	37
38 Doors	2009	5,097						38
39 Seal and Stripe Parking Lot	2008	3,715						39
40 Grease Trap	2009	4,875						40
41 Telephone System	2008	20,911						41
42 New Windows	2009	2,625						42
43 Carpet	2010	11,593						43
44 Doors	2010	4,402						44
45 Countertops	2010	2,570						45
46 Replace Sidewalks	2009	10,980						46
47 Sealcoat Parking Lot	2010	4,855						47
48 HVAC	2010	3,035						48
49 Sinks	2011	7,968						49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 85,166	\$ 363		\$ 363	\$	\$ 1,240	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	\$ 8,867	\$	\$ 1,686	\$ 1,686	4	\$ 6,373
77									77
78									78
79									79
80	TOTALS			\$ 8,867	\$	\$ 1,686	\$ 1,686		\$ 6,373

E. Summary of Care-Related Assets				1	2
		Reference			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)			\$ 94,033
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 363
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 2,049
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$ 1,686
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 7,613

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	\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92	Section Not Applicable	\$
93		
94		
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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Moline 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:	1990	120	12/1/07	\$ 1,018,740	4	Unlimited	3
4	Additions							4
5								5
6								6
7	TOTAL		120		\$ 1,018,740			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?
16. Rental Amount for movable equipment: \$ Not Specified Description:

☒ YES

☐ NO

(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	Section Not Applicable		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning 12/1/07

Ending 11/30/11

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

Fiscal Year Ending Annual Rent

12. 6/30/2012 \$ 105,840
13. \$
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.

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

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

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2		3	4	5	6	7	8			
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)				
			Units of Service	Cost	Units	Cost							
1	Licensed Occupational Therapist	10a, 8	hrs	\$	15,027	\$	240,740	\$	15,027	\$	240,740	1	
2	Licensed Speech and Language Development Therapist	10a, 8	hrs		4,596		98,163		4,596		98,163	2	
3	Licensed Recreational Therapist		hrs									3	
4	Licensed Physical Therapist	10a, 8	hrs		18,528		319,171	4,426	18,528		323,597	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					232,181			232,181	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10	
11	Academic Education		hrs									11	
12	Other (specify): <u>Labs, X-Rays, Internal</u>	39, 3					41,221				41,221	12	
13	Other (specify): _____											13	
14	TOTAL			\$	38,151	\$	699,295	\$	236,607	38,151	\$	935,902	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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 161,814	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 90,000)	568,892		3
4	Supply Inventory (priced at Cost)	2,627		4
5	Short-Term Investments			5
6	Prepaid Insurance	17,705		6
7	Other Prepaid Expenses	3,434		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 754,472	\$	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	2,540		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(1,240)		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)	\$ 3,300	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 757,772	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 197,890	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	170,792		30
31	Accrued Taxes Payable (excluding real estate taxes)	19,508		31
32	Accrued Real Estate Taxes(Sch.IX-B)	121,815		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	(40,994)		35
	Other Current Liabilities(specify):			
36	Accrued Expenses	76,983		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 545,994	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	769,549		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)	\$ 769,549	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,315,543	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (557,771)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 757,772	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (275,203)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (275,203)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(282,568)	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)	\$ (282,568)	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)	\$ (557,771)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROSEWOOD CARE CENTER OF MOLINE

0049304

Report Period Beginning: 7/1/2010

Ending: 6/30/2011

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.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,303,757	1
2	Discounts and Allowances for all Levels	(2,036,219)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,267,538	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,768,943	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,768,943	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	1,800	13
14	Non-Patient Meals	6,915	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 8,715	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,010	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,010	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Vendor Discount</u>	900	28
28a	<u>Miscellaneous Other Income</u>	1,084	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,984	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,049,190	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	933,480	31
32	Health Care	2,816,768	32
33	General Administration	1,071,698	33
	B. Capital Expense		
34	Ownership	1,211,704	34
	C. Ancillary Expense		
35	Special Cost Centers	273,402	35
36	Provider Participation Fee	65,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,372,752	40
41	Income before Income Taxes (line 30 minus line 40)**	(323,562)	41
42	Income Taxes	(40,994)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (282,568)	43

* 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

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	2,116	2,232	\$ 59,463	\$ 26.64	1
2	Assistant Director of Nursing	1,928	2,033	52,362	25.76	2
3	Registered Nurses	23,323	24,598	563,464	22.91	3
4	Licensed Practical Nurses	15,654	16,510	310,384	18.80	4
5	CNAs & Orderlies	59,385	62,632	672,826	10.74	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,952	4,168	64,303	15.43	8
9	Activity Director					9
10	Activity Assistants	5,589	5,895	62,234	10.56	10
11	Social Service Workers	3,433	3,621	41,875	11.56	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,516	19,529	211,846	10.85	15
16	Dishwashers					16
17	Maintenance Workers	2,078	2,192	30,219	13.79	17
18	Housekeepers	14,070	14,839	140,577	9.47	18
19	Laundry	3,765	3,971	34,536	8.70	19
20	Administrator	1,795	1,893	70,869	37.44	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,258	11,874	147,321	12.41	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	4,484	4,729	64,649	13.67	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	171,346	180,716	\$ 2,526,928 *	\$ 13.98	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Contract	\$ 9,604	1,3	35
36	Medical Director	Contract	16,200	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	6,832	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	2,600	11,3	44
45	Social Service Consultant	Contract	2,600	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 37,836		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	41	\$ 1,933	10-3	50
51	Licensed Practical Nurses	327	11,723	10-3	51
52	Certified Nurse Assistants/Aides	438	10,433	10-3	52
53	TOTAL (lines 50 - 52)	806	\$ 24,089		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** 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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	Schedule Not Applicable		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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 \$4,158
- (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?

7
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$

43,963

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

N/A

NO

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.

\$

65,700

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.

\$

6,915
- (16)

Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

N/A

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$

N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

N/A

d. Have vehicle usage logs been maintained?

N/A

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

N/A

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$

No
- (17)

Has an audit been performed by an independent certified public accounting firm?

No

Firm Name:

N/A
- (18)

Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V?

Yes
- (19)

If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

Yes

Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT