

		FOR BHF USE					

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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: <u>0049031</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>ROSEWOOD CARE CTR-EDWARDSVILLE</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/2010</u> to <u>6/30/2011</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
Address: <u>6277 Center Grove Road</u> <u>Edwardsville</u> <u>62025</u>																											
NumberCityZip Code																											
County: <u>Madison</u>																											
Telephone Number: <u>(618)659-0605</u> Fax # <u>(618)659-0627</u>																											
HFS ID Number: _____		Officer or Administrator of Provider Paid Preparer																									
Date of Initial License for Current Owners: <u>10/1/2007</u>																											
Type of Ownership:																											
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☒ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>				☐ 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 _____	
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	☐ "Sub-S" Corp.																										
	☐ Limited Liability Co.																										
	☐ Trust																										
	☐ Other _____																										
In the event there are further questions about this report, please contact:		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																									
Name: <u>Cindy A. Tefteller</u> Telephone Number: <u>(618)465-7717</u>																											
Email Address: _____																											

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROSEWOOD CARE CTR-EDWARDSVILLE

0049031 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>8,926</u>	<u>8,926</u>	8
9	SNF/PED					9
10	ICF	<u>6,624</u>	<u>12,374</u>		<u>18,998</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>6,624</u>	<u>12,374</u>	<u>8,926</u>	<u>27,924</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.75%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

☐

NO

X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

☐

NO

X

I. On what date did you start providing long term care at this location?

Date started 10/1/2007

J. Was the facility purchased or leased after January 1, 1978?

YES

☒

Date

10/1/07

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

8,926

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 CTR-EDWARDSVILL # 0049031 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	207,151	18,036	7,217	232,404		232,404		232,404			1
2	Food Purchase		158,882		158,882		158,882	(3,767)	155,115			2
3	Housekeeping	133,861	39,669		173,530		173,530		173,530			3
4	Laundry	48,246	14,587		62,833		62,833		62,833			4
5	Heat and Other Utilities			118,803	118,803		118,803		118,803			5
6	Maintenance	45,207	7,105	221,678	273,990		273,990	(76,601)	197,389			6
7	Other (specify):* Garbage Collection			13,642	13,642		13,642		13,642			7
8	TOTAL General Services	434,465	238,279	361,340	1,034,084		1,034,084	(80,368)	953,716			8
	B. Health Care and Programs											
9	Medical Director			21,600	21,600		21,600		21,600			9
10	Nursing and Medical Records	2,030,609	209,579	140,201	2,380,389		2,380,389	33,811	2,414,200			10
10a	Therapy	76,773	9,125	914,159	1,000,057		1,000,057	(24,879)	975,178			10a
11	Activities	53,194	3,658	2,400	59,252		59,252		59,252			11
12	Social Services	49,648		2,400	52,048		52,048		52,048			12
13	CNA Training											13
14	Program Transportation			6	6		6		6			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,210,224	222,362	1,080,766	3,513,352		3,513,352	8,932	3,522,284			16
	C. General Administration											
17	Administrative	75,370		138,000	213,370		213,370	(138,000)	75,370			17
18	Directors Fees											18
19	Professional Services			289,268	289,268		289,268	(261)	289,007			19
20	Dues, Fees, Subscriptions & Promotions			29,681	29,681	2,590	32,271	(5,914)	26,357			20
21	Clerical & General Office Expenses	170,036	24,717	12,696	207,449		207,449	(16,699)	190,750			21
22	Employee Benefits & Payroll Taxes			385,202	385,202		385,202	19,429	404,631			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,171	3,171	(2,590)	581	3,987	4,568			24
25	Other Admin. Staff Transportation			15,322	15,322		15,322	(6,791)	8,531			25
26	Insurance-Prop.Liab.Malpractice			30,926	30,926		30,926	1,668	32,594			26
27	Other (specify):*											27
28	TOTAL General Administration	245,406	24,717	904,266	1,174,389		1,174,389	(142,581)	1,031,808			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,890,095	485,358	2,346,372	5,721,825		5,721,825	(214,017)	5,507,808			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			999	999		999	2,798	3,797			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							14,080	14,080			32
33	Real Estate Taxes			87,735	87,735		87,735		87,735			33
34	Rent-Facility & Grounds			1,202,481	1,202,481		1,202,481		1,202,481			34
35	Rent-Equipment & Vehicles			46,641	46,641		46,641		46,641			35
36	Other (specify):*											36
37	TOTAL Ownership			1,337,856	1,337,856		1,337,856	16,878	1,354,734			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		336,793	70,131	406,924		406,924		406,924			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		336,793	135,831	472,624		472,624		472,624			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,890,095	822,151	3,820,059	7,532,305		7,532,305	(197,139)	7,335,166			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	(2,502)	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	(5,575)	32		10
11	Discounts, Allowances, Rebates & Refunds	(916)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(349)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,456)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,730)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(627)	20		28
29	Other-Attach Schedule	(80,073)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (98,228)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	(98,911)	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (98,911)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (197,139)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Report Period Beginning:
Ending:

ID# 0049031
7/1/2010
6/30/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Eliminate Marketing Salary	\$ (64,084)	21	1
2	Eliminate Marketing Mileage	(13,277)	25	2
3	Eliminate Lobbying & PAC Dues	(2,712)	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	(80,073)		49

Summary A

6/30/2011

[illegible]

Summary B

6/30/2011

[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		Supportive Living
		Bravo Care of East Peoria, Inc.	East Peoria, IL	River, Inc.	Wood River, IL	Facility
		Bravo Care of Elgin, Inc.	Elgin, IL	Bravo Nursing Home		
		Bravo Care of Galesburg, Inc.	Galesburg, IL	Services, Inc.	St. Louis, MO	Management Co.
		Bravo Care of Inverness, Inc.	Inverness, IL	Bravo Holding Co.	St. Louis, MO	Holding Co.
		Bravo Care of Joliet, Inc.	Joliet, IL	Bravo Therapy		
		Bravo Care of Moline, Inc.	Moline, IL	Services, Inc.	St. Louis, MO	Therapy Co.

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)	
1	V	10	See Schedule VIII	\$	Bravo Nursing Home Services, Inc.	100.00%	\$ 33,811	\$ 33,811	1
2	V	10a	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	7,581	7,581	2
3	V	19	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	308	308	3
4	V	20	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	53	53	4
5	V	21	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	46,683	46,683	5
6	V	22	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	15,426	15,426	6
7	V	24	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	1,971	1,971	7
8	V	25	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	2,636	2,636	8
9	V	26	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	427	427	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	310,811	Bravo Therapy Services, Inc.		278,351	(32,460)	13
14	Total			\$ 448,811			\$ 387,247	\$ * (61,564)	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.

☒ 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	\$ 158,488	Senior Living Services, Inc.		\$ 81,887	\$ (76,601)	15
16	V	21	Clerical & Office Expenses		Senior Living Services, Inc.		702	702	16
17	V	22	Payroll Taxes & Emp Ben.		Senior Living Services, Inc.		4,003	4,003	17
18	V	24	Travel & Seminar		Senior Living Services, Inc.		2,016	2,016	18
19	V	25	Other Admin Staff Transportation		Senior Living Services, Inc.		3,850	3,850	19
20	V	26	Insurance		Senior Living Services, Inc.		914	914	20
21	V	30	Depreciation		Senior Living Services, Inc.		2,798	2,798	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	19	Professional Services		Bravo Holding Company		4,887	4,887	26
27	V	20	Dues & Subscriptions		Bravo Holding Company		102	102	27
28	V	26	Insurance		Bravo Holding Company		327	327	28
29	V	32	Interest		Bravo Holding Company		19,655	19,655	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			\$ 158,488			\$ 121,141	\$ * (37,347)	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	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 Health,		Human Resources	3
4			Bravo Care of St. Charles, Inc.	St. Charles, IL	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

Facility Name & ID Number ROSEWOOD CARE CTR-EDWARDSVIL # 0049031 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	156,650	4.07	6.79	Salary	\$ 11,407	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	\$ 11,407		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROSEWOOD CARE CTR-EDWARDSVILLE # 0049031 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	\$ 498,142	7,274,484	\$ 33,811	1
2	10a	Therapy	Total Cost	107,176,506	15	111,686	111,686	7,274,484	7,581	2
3	19	Professional Services	Total Cost	107,176,506	15	4,531		7,274,484	308	3
4	20	Dues & Subscriptions	Total Cost	107,176,506	15	777		7,274,484	53	4
5	21	Salaries - Other	Total Cost	107,176,506	15	674,650	674,650	7,274,484	45,791	5
6	21	Taxes, Licenses & Office Supplies	Total Cost	107,176,506	15	2,803		7,274,484	190	6
7	21	Telephone	Total Cost	107,176,506	15	10,343		7,274,484	702	7
8	22	Payroll Taxes	Total Cost	107,176,506	15	93,441		7,274,484	6,342	8
9	22	Employee Benefits	Total Cost	107,176,506	15	133,835		7,274,484	9,084	9
10	24	Travel & Seminar	Total Cost	107,176,506	15	29,046		7,274,484	1,971	10
11	25	Administrative Transportation	Total Cost	107,176,506	15	38,835		7,274,484	2,636	11
12	26	Insurance	Total Cost	107,176,506	15	6,296		7,274,484	427	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	\$ 1,284,478		\$ 108,896	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	19,655	6	
7												7	
8	Less: Interest Income Offset										(5,575)	8	
9	TOTAL Facility Related						\$	\$			\$ 14,080	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$	\$			\$ 14,080	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.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	142,089	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.)				\$	108,765	2																				
3. Under or (over) accrual (line 2 minus line 1).				\$	(33,324)	3																				
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	121,059	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.				\$	87,735	7																				
Real Estate Tax History:																										
Real Estate Tax Bill for Calendar Year:		2006	99,072	8	<table><tr><td></td><td colspan="2">FOR BHF USE ONLY</td><td></td></tr><tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2010</td><td>\$</td><td>13</td></tr><tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr><tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr><tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr></table>			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
	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																							
	2007	106,467	9																							
	2008	101,552	10																							
	2009	112,770	11																							
	2010	96,746	12																							
2009 Payment = \$84,579 + 2010 Payment = \$24,186																										
Accrual = Remaining 2010 tax bill (\$72,559) + 1/2 estimated 2011 tax bill (\$48,500)																										

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 ROSEWOOD CARE CTR-EDWARDSVILLE COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0049031

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</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>14-1-15-22-00-000-002.004</u>	<u>S PT SE 15 & N PT NE 22</u>	\$ <u>96,745.64</u>	\$ <u>96,745.64</u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></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><u>96,745.64</u></u>	\$ <u><u>96,745.64</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 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	Wallpaper for 37 guest rooms			2008	6,993	999	7	999		3,330
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

See Page 12A, Line 70 for total
 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	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 10/1/07-6/30/11		\$	\$		\$	\$	\$	37
38 Wall Repair	2010	9,158						38
39 Sprinkler System	2010	7,634						39
40 Plumbing	2010	3,308						40
41 Locks and Keys	2010	2,541						41
42 Sheet Metal on Roof	2011	3,913						42
43 Tuckpointing	2011	4,800						43
44 Sprinkler System	2010	13,108						44
45 Hot Water Repiping	2010	5,042						45
46 Cooling Tower	2011	81,277						46
47 Patch & Seal Parking Lot	2010	12,330						47
48 HVAC	2011	3,658						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 TOTAL (lines 4 thru 69)		\$ 153,762	\$ 999		\$ 999	\$	\$ 3,330	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	\$14,715	\$	\$2,798	\$2,798	4	\$10,577	76
77										77
78										78
79										79
80	TOTALS			\$14,715	\$	\$2,798	\$2,798		\$10,577	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)	\$168,477	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$999	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$3,797	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$2,798	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$13,907	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Edwardsville Real Estate, L.L.C.
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☒ 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>1995</u>	<u>120</u>	<u>10/1/07</u>	\$ <u>1,202,481</u>	<u>4</u>	<u>Unlimited</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		120		\$ 1,202,481			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: _____ *

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

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO
16. Rental Amount for movable equipment: \$ Not Specified Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning 10/1/07
Ending 6/30/11

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

	Fiscal Year Ending	Annual Rent
12.		\$
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	\$	22,162	\$	364,548	\$	22,162	\$	364,548	1	
2	Licensed Speech and Language Development Therapist	10a,8	hrs		6,392		150,350		6,392		150,350	2	
3	Licensed Recreational Therapist		hrs									3	
4	Licensed Physical Therapist	10a,8	hrs		23,139		366,801	9,125	23,139		375,926	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					336,793			336,793	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10	
	Academic Education		hrs									11	
12	Other (specify): <u>Labs,X-Rays,Enterals</u>	39, 3					70,131				70,131	12	
13	Other (specify): _____											13	
14	TOTAL			\$	51,693	\$	951,830	\$	345,918	51,693	\$	1,297,748	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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 100,269	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 65,000)	647,197		3
4	Supply Inventory (priced at Cost)	2,426		4
5	Short-Term Investments			5
6	Prepaid Insurance	20,524		6
7	Other Prepaid Expenses	3,434		7
8	Accounts Receivable (owners or related parties)	136,073		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 909,923	\$	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	6,993		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(3,330)		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	2,467		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,130	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 916,053	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 202,090	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	187,966		30
31	Accrued Taxes Payable (excluding real estate taxes)	19,046		31
32	Accrued Real Estate Taxes(Sch.IX-B)	121,059		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	5,707		35
	Other Current Liabilities(specify):			
36	Accrued Expenses	85,245		36
37	Accrued Rent	22,087		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 643,200	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 643,200	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 272,853	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 916,053	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 218,301	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 218,301	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	54,552	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)	\$ 54,552	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)	\$ 272,853	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **ROSEWOOD CARE CTR-EDWARDSVILLE**# **0049031**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	\$ 7,944,831	1
2	Discounts and Allowances for all Levels	(2,772,320)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,172,511	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,408,372	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,408,372	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	2,400	13
14	Non-Patient Meals	2,502	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)	\$ 4,902	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,575	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,575	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	288	28
28a	Vendor Discount	916	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,204	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,592,564	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,034,084	31
32	Health Care	3,513,352	32
33	General Administration	1,174,389	33
	B. Capital Expense		
34	Ownership	1,337,856	34
	C. Ancillary Expense		
35	Special Cost Centers	406,924	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)*	\$ 7,532,305	40
41	Income before Income Taxes (line 30 minus line 40)**	60,259	41
42	Income Taxes	5,707	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 54,552	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	1,846	1,955	\$ 66,138	\$ 33.83	1
2	Assistant Director of Nursing	1,935	2,049	58,127	28.37	2
3	Registered Nurses	28,481	30,162	862,481	28.59	3
4	Licensed Practical Nurses	12,495	13,233	278,307	21.03	4
5	CNAs & Orderlies	60,729	64,314	697,826	10.85	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,623	3,837	76,773	20.01	8
9	Activity Director					9
10	Activity Assistants	5,219	5,527	53,194	9.62	10
11	Social Service Workers	3,882	4,112	49,648	12.07	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,167	21,357	207,151	9.70	15
16	Dishwashers					16
17	Maintenance Workers	2,224	2,356	45,207	19.19	17
18	Housekeepers	13,077	13,848	133,861	9.67	18
19	Laundry	4,483	4,747	48,246	10.16	19
20	Administrator	1,853	1,962	75,370	38.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,081	11,735	170,036	14.49	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	4,031	4,269	67,730	15.87	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	175,126	185,463	\$ 2,890,095 *	\$ 15.58	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	\$ 7,217	1,3	35
36	Medical Director	Contract	21,600	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	4,322	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)		\$ 37,939		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	597	\$ 25,974	10-3	50
51	Licensed Practical Nurses	1,350	40,675	10-3	51
52	Certified Nurse Assistants/Aides	3,692	69,230	10-3	52
53	TOTAL (lines 50 - 52)	5,639	\$ 135,879		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 \$4,157
- (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.

\$

46,534

Line

10
- (7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.
- (8)

Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A
- (9)

Are you presently operating under a sublease agreement?

YES

X

NO
- (10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

N/A
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$

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.

\$

2,502
- (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?

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 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