

		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>0049346</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																																																							
Facility Name: <u>ROSEWOOD CARE CTR OF ELGIN</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/10</u> to <u>6/30/11</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>2355 Royal Boulevard</u> <u>Elgin</u> <u>60123</u>																																																																																									
Number City Zip Code																																																																																									
County: <u>Kane</u>																																																																																									
Telephone Number: <u>(847)888-9585</u> Fax # <u>(847)888-4173</u>																																																																																									
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROSEWOOD CARE CTR OF ELGIN

0049346 Report Period Beginning: 7/1/10 Ending: 6/30/11

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>139</u>	Skilled (SNF)	<u>139</u>	<u>50,735</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>139</u>	TOTALS	<u>139</u>	<u>50,735</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>9,887</u>	<u>9,887</u>	8
9	SNF/PED					9
10	ICF	<u>12,884</u>	<u>16,027</u>		<u>28,911</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>12,884</u>	<u>16,027</u>	<u>9,887</u>	<u>38,798</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.47%

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 48 and days of care provided 9,887

Medicare Intermediary Pinnacle Business Solutions, Inc.

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 6/30/11 Fiscal Year: 6/30/11

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

Facility Name & ID Number		ROSEWOOD CARE CTR OF ELGIN				#	0049346	Report Period Beginning:		7/1/10	Ending: 6/30/11	
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	235,469	24,450	14,276	274,195		274,195		274,195			1
2	Food Purchase		192,949		192,949		192,949	(5,191)	187,758			2
3	Housekeeping	144,981	37,497		182,478		182,478		182,478			3
4	Laundry	61,079	19,310		80,389		80,389		80,389			4
5	Heat and Other Utilities			192,495	192,495		192,495		192,495			5
6	Maintenance	31,538	10,222	204,150	245,910		245,910	(57,518)	188,392			6
7	Other (specify):* Garbage Collection			17,211	17,211		17,211		17,211			7
8	TOTAL General Services	473,067	284,428	428,132	1,185,627		1,185,627	(62,709)	1,122,918			8
	B. Health Care and Programs											
9	Medical Director			2,875	2,875		2,875		2,875			9
10	Nursing and Medical Records	2,882,368	246,659	6,132	3,135,159		3,135,159	41,047	3,176,206			10
10a	Therapy	177,378	2,260	757,871	937,509		937,509	(11,072)	926,437			10a
11	Activities	66,456	4,049	2,400	72,905		72,905		72,905			11
12	Social Services	79,569		2,400	81,969		81,969		81,969			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,205,771	252,968	771,678	4,230,417		4,230,417	29,975	4,260,392			16
	C. General Administration											
17	Administrative	70,254		138,000	208,254		208,254	(138,000)	70,254			17
18	Directors Fees											18
19	Professional Services			345,219	345,219		345,219	1,275	346,494			19
20	Dues, Fees, Subscriptions & Promotions			23,891	23,891	2,625	26,516	(7,579)	18,937			20
21	Clerical & General Office Expenses	210,891	33,575	31,291	275,757		275,757	(28,503)	247,254			21
22	Employee Benefits & Payroll Taxes			479,660	479,660		479,660	22,035	501,695			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,364	3,364	(2,625)	739	4,059	4,798			24
25	Other Admin. Staff Transportation			3,100	3,100		3,100	4,011	7,111			25
26	Insurance-Prop.Liab.Malpractice			116,910	116,910		116,910	1,671	118,581			26
27	Other (specify):*											27
28	TOTAL General Administration	281,145	33,575	1,141,435	1,456,155		1,456,155	(141,031)	1,315,124			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,959,983	570,971	2,341,245	6,872,199		6,872,199	(173,765)	6,698,434			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			2,474	2,474		2,474	2,312	4,786			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			118,157	118,157		118,157		118,157			33
34	Rent-Facility & Grounds			1,515,150	1,515,150		1,515,150		1,515,150			34
35	Rent-Equipment & Vehicles			39,921	39,921		39,921		39,921			35
36	Other (specify):*											36
37	TOTAL Ownership			1,675,702	1,675,702		1,675,702	2,312	1,678,014			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		392,725	45,944	438,669		438,669		438,669			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			76,103	76,103		76,103		76,103			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		392,725	122,047	514,772		514,772		514,772			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,959,983	963,696	4,138,994	9,062,673		9,062,673	(171,453)	8,891,220			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	(3,701)	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	(23,862)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,095)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(395)	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	(5,031)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,211)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,409)	20		28
29	Other-Attach Schedule	(90,274)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (129,978)		\$	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)	(41,475)	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (41,475)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (171,453)		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

Report Period Beginning:

Ending:

ID#

0049346

7/1/10

6/30/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Eliminate Marketing Salary	\$ (85,758)	21	1
2	Eliminate Marketing Mileage	(2,370)	25	2
3	Eliminate Lobbying & PAC Dues	(3,141)	20	3
4	Record IDPH License Fee	995	20	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
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41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(90,274)		49

Summary A

6/30/11

[illegible]

Summary B

6/30/11

[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 Galesburg, Inc.	Galesburg, IL		St. Louis, MO	Management Co.
		Bravo Care of Inverness, Inc.	Inverness, IL			
		Bravo Care of Joliet, Inc.	Joliet, IL		St. Louis, MO	Holding Co.
		Bravo Care of Moline, Inc.	Moline, 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%	\$ 41,047	\$ 41,047	1
2	V	10a	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	9,203	9,203	2
3	V	19	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	373	373	3
4	V	20	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	64	64	4
5	V	21	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	56,675	56,675	5
6	V	22	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	18,728	18,728	6
7	V	24	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	2,393	2,393	7
8	V	25	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	3,200	3,200	8
9	V	26	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	519	519	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	177,792	Bravo Therapy Services, Inc.		157,517	(20,275)	13
14	Total			\$ 315,792			\$ 289,719	\$ * (26,073)	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	\$ 139,202	Senior Living Services, Inc.		\$ 81,684	\$ (57,518)	15
16	V	21	Clerical & Office Expenses		Senior Living Services, Inc.		580	580	16
17	V	22	Payroll Taxes & Emp. Ben.		Senior Living Services, Inc.		3,307	3,307	17
18	V	24	Travel & Seminar		Senior Living Services, Inc.		1,666	1,666	18
19	V	25	Other Admin Staff Transportation		Senior Living Services, Inc.		3,181	3,181	19
20	V	26	Insurance		Senior Living Services, Inc.		755	755	20
21	V	30	Depreciation		Senior Living Services, Inc.		2,312	2,312	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	19	Professional Services		Bravo Holding Company		5,933	5,933	26
27	V	20	Dues & Subscriptions		Bravo Holding Company		123	123	27
28	V	26	Insurance		Bravo Holding Company		397	397	28
29	V	32	Interest		Bravo Holding Company		23,862	23,862	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			\$ 139,202			\$ 123,800	\$ * (15,402)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	154,209	4.94	8.24	Salary	\$ 13,848	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	\$ 13,848		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

Ending: 6/30/11

(314)994-9912

SEE ACCOUNTANTS' COMPILATION REPORT

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	23,862	6	
7												7	
8	Less: Interest Income Offset										(23,862)	8	
9	TOTAL Facility Related						\$	\$			\$	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$	\$			\$	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.)

SEE ACCOUNTANTS' COMPILATION REPORT

FACILITY NAME	<u>ROSEWOOD CARE CTR OF ELGIN</u>	COUNTY	<u>Kane</u>
FACILITY IDPH LICENSE NUMBER	<u>0049346</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>Chuck Schmitz</u>		
TELEPHONE	(314)994-9070	FAX #:	(314)994-9912

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.

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: 43,268

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

E. 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										9
10		Flooring in 200 Hall	2008		4,131	590	7	590		1,967
11		Carpet for Lobby & Lounge	2009		7,053	1,007	7	1,007		2,519
12		Wallpaper Headwalls for Guest Rooms	2008		3,350	479	7	479		1,436
13		Repair Drywall & Paint	2009		2,785	398	7	398		630
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 Seal and Stripe Parking Lot	2008	3,000						38
39 Pipe Fittings	2008	3,451						39
40 Cooling Tower	2008	96,723						40
41 New Doors	2009	9,617						41
42 Sewer Drain Line	2009	21,165						42
43 Parking Lot Resurfacing	2008	24,500						43
44 Trash Enclosure	2009	40,241						44
45 Key Pad and Intercom for Entry Doors	2008	4,051						45
46 Telephone System	2008	24,736						46
47 Signage	2009	4,018						47
48 Tuckpointing	2010	4,622						48
49 Fire Alarm System	2010	45,950						49
50 Doors	2010	14,030						50
51 Compressors	2010	2,560						51
52 Concrete Drive in Front of Dumpster	2009	9,480						52
53 Patch and Seal Coat Parking Lot	2010	3,985						53
54 Wall Repair & Covering	2010	8,942						54
55 Doors	2010	9,844						55
56 Asphalt	2010	3,620						56
57 Drywall & Paint	2011	3,598						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)		\$ 355,452	\$ 2,474		\$ 2,474	\$	\$ 6,552	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	\$12,157	\$	\$2,312	\$2,312	4	\$8,738	76
77										77
78										78
79										79
80	TOTALS			\$12,157	\$	\$2,312	\$2,312		\$8,738	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)	\$367,609	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$2,474	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$4,786	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$2,312	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$15,290	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: Elgin 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:	1994	139	12/1/07	\$ 1,515,150	3	Unlimited	3
4	Additions							4
5								5
6	Related Party Allocaiton of Storage Unit							6
7	TOTAL		139		\$ 1,515,150			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
- None

N/A

N/A

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

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

15. Is Movable equipment rental included in building rental?
- ☒ YES
- ☐ NO
16. Rental Amount for movable equipment: \$ Not Specified
- Description:

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	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 10/31/10

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	\$	19,590	\$ 299,364	\$	19,590	\$ 299,364	1
2	Licensed Speech and Language Development Therapist	10a, 8	hrs		3,320	69,880		3,320	69,880	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 8	hrs		24,622	368,351	2,260	24,622	370,611	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				392,725		392,725	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)									
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Lab,X-Ray,Amb,Enter</u>	39,3				45,944			45,944	12
13	Other (specify): <u> </u>									

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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 125,036	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 120,000)	732,859		3
4	Supply Inventory (priced at Cost)	2,961		4
5	Short-Term Investments			5
6	Prepaid Insurance	25,847		6
7	Other Prepaid Expenses	3,978		7
8	Accounts Receivable (owners or related parties)	796,358		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,687,039	\$	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	17,319		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(6,552)		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)	\$ 12,767	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,699,806	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 222,637	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	331,274		30
31	Accrued Taxes Payable (excluding real estate taxes)	24,921		31
32	Accrued Real Estate Taxes(Sch.IX-B)	117,259		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	93,728		35
	Other Current Liabilities(specify):			
36	Accrued Expenses	92,259		36
37	Accrued Rent	40,100		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 922,178	\$	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)	\$ 922,178	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 777,628	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,699,806	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 577,526	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 577,526	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	477,602	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	(277,500)	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)	\$ 200,102	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)	\$ 777,628	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	1
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 10,135,674	1
2	Discounts and Allowances for all Levels	(2,760,010)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,375,664	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,224,235	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,224,235	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	3,701	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)	\$ 6,101	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	24,886	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 24,886	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	2,022	28
28a	Vendor Discount	1,095	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,117	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,634,003	30

	Expenses	Amount	2
	A. Operating Expenses		
31	General Services	1,185,627	31
32	Health Care	4,230,417	32
33	General Administration	1,456,155	33
	B. Capital Expense		
34	Ownership	1,675,702	34
	C. Ancillary Expense		
35	Special Cost Centers	438,669	35
36	Provider Participation Fee	76,103	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,062,673	40
41	Income before Income Taxes (line 30 minus line 40)**	571,330	41
42	Income Taxes	93,728	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 477,602	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	2,023	2,170	\$ 89,590	\$ 41.29	1
2	Assistant Director of Nursing	1,932	2,072	77,112	37.22	2
3	Registered Nurses	32,290	34,630	1,113,801	32.16	3
4	Licensed Practical Nurses	16,345	17,529	439,067	25.05	4
5	CNAs & Orderlies	76,876	82,446	1,035,983	12.57	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,667	8,223	177,378	21.57	8
9	Activity Director					9
10	Activity Assistants	5,180	5,555	66,456	11.96	10
11	Social Service Workers	4,362	4,678	79,569	17.01	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,822	22,330	235,469	10.54	15
16	Dishwashers					16
17	Maintenance Workers	2,173	2,331	31,538	13.53	17
18	Housekeepers	14,331	15,369	144,981	9.43	18
19	Laundry	6,463	6,931	61,079	8.81	19
20	Administrator	1,674	1,795	70,254	39.14	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,433	13,334	210,891	15.82	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,840	6,264	126,815	20.25	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	210,411	225,657	\$ 3,959,983 *	\$ 17.55	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	\$ 14,276	1,3	35
36	Medical Director	Contract	2,875	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	6,107	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)		\$ 28,058		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	2	25	10-3	52
53	TOTAL (lines 50 - 52)	2	\$ 25		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

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

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					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 \$4,815

(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.

\$63,822

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.

\$76,103

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.

\$3,701

(16) Travel and Transportation

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

No

If YES, attach a complete explanation.

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

No

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

\$N/A

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

N/A

d. Have vehicle usage logs been maintained?

N/A

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

N/A

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

N/A

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

No

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

\$N/A

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

No

Firm Name:

N/A

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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