FOR BHF USE

LL1

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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: 0049023

Facility Name: Rosewood Care Ctr Inverness

Address: 1800 Colonial Parkway (Number) Inverness (City) 60067 (Zip Code)

County: Cook

Telephone Number: (847) 776-4700 **Fax #** (847) 991-4104

HFS ID Number:

Date of Initial License for Current Owners: 10/1/2007

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2009 to 6/30/2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) See Accountant's Compilation Report (Date)
(Print Name and Title) Cindy A. Tefteller
(Firm Name & Address) C.J. Schlosser & Company, L.L.C. 233 E. Center Drive, Alton, IL 62002
(Telephone) (618) 465-7717 Fax # (618) 465-7710

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	142	Skilled (SNF)	142	51,830	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	142	TOTALS	142	51,830	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			8,583	8,583	8
9	SNF/PED					9
10	ICF	9,297	13,401		22,698	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,297	13,401	8,583	31,281	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.35%

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 10/1/07

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/1/07 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 58 and days of care provided 8,583

Medicare Intermediary Pinnacle Business Solutions, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/10 Fiscal Year: 6/30/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	222,289	23,970	9,156	255,415		255,415		255,415			1
2	Food Purchase		170,473		170,473		170,473	(3,645)	166,828			2
3	Housekeeping	173,490	50,807		224,297		224,297		224,297			3
4	Laundry	47,312	16,304		63,616		63,616		63,616			4
5	Heat and Other Utilities			183,855	183,855		183,855		183,855			5
6	Maintenance	28,324	7,296	235,668	271,288		271,288	(49,198)	222,090			6
7	Other (specify):* Garbage Collection			14,642	14,642		14,642		14,642			7
8	**TOTAL General Services**	471,415	268,850	443,321	1,183,586		1,183,586	(52,843)	1,130,743			8
	B. Health Care and Programs											
9	Medical Director			13,050	13,050		13,050		13,050			9
10	Nursing and Medical Records	2,566,589	174,799	5,075	2,746,463		2,746,463		2,746,463			10
10a	Therapy	79,681	15,296	765,861	860,838		860,838	93,648	954,486			10a
11	Activities	67,570	3,563	2,388	73,521		73,521		73,521			11
12	Social Services	60,915		3,402	64,317		64,317		64,317			12
13	CNA Training											13
14	Program Transportation			9	9		9		9			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,774,755	193,658	789,785	3,758,198		3,758,198	93,648	3,851,846			16
	C. General Administration											
17	Administrative	91,437		138,000	229,437		229,437	(138,000)	91,437			17
18	Directors Fees											18
19	Professional Services			295,443	295,443		295,443	(11,102)	284,341			19
20	Dues, Fees, Subscriptions & Promotions			23,692	23,692	1,990	25,682	(10,305)	15,377			20
21	Clerical & General Office Expenses	200,556	27,765	38,429	266,750		266,750	7,307	274,057			21
22	Employee Benefits & Payroll Taxes			442,594	442,594		442,594	(21,345)	421,249			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,977	2,977	(1,990)	987	6,122	7,109			24
25	Other Admin. Staff Transportation			9,879	9,879		9,879	(3,023)	6,856			25
26	Insurance-Prop.Liab.Malpractice			41,116	41,116		41,116	1,899	43,015			26
27	Other (specify):*											27
28	**TOTAL General Administration**	291,993	27,765	992,130	1,311,888		1,311,888	(168,447)	1,143,441			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,538,163	490,273	2,225,236	6,253,672		6,253,672	(127,642)	6,126,030			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rosewood Care Ctr Inverness #0049023 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation							3,528	3,528			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			52,993	52,993		52,993	(52,993)				32
33	Real Estate Taxes			673,911	673,911		673,911		673,911			33
34	Rent-Facility & Grounds			957,593	957,593		957,593	86	957,679			34
35	Rent-Equipment & Vehicles			25,235	25,235		25,235		25,235			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,709,732	1,709,732		1,709,732	(49,379)	1,660,353			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		392,668	33,478	426,146		426,146		426,146			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			77,745	77,745		77,745		77,745			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		392,668	111,223	503,891		503,891		503,891			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,538,163	882,941	4,046,191	8,467,295		8,467,295	(177,021)	8,290,274			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

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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	(2,107)	2		4
5	Telephone, TV & Radio in Resident Rooms	(11,432)	21		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				10
11	Discounts, Allowances, Rebates & Refunds	(1,176)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(362)	2		13
14	Non-Care Related Interest	(52,993)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(13,033)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,776)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,541)	20		28
29	Other-Attach Schedule	(137,950)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (226,370)		$	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)	49,349	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 49,349		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (177,021)		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

Rosewood Care Ctr Inverness

ID# 0049023

Report Period Beginning: 7/1/2009

Ending: 6/30/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate Marketing Salary	$ (84,043)	21	1
2	Eliminate Marketing Mileage	(9,509)	25	2
3	Offset IL Unemployment Refund	(40,781)	22	3
4	Eliminate Lobbying & PAC Dues	(2,622)	20	4
5	Eliminate Out of Period IDPH License Fees	(995)	20	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**	(137,950)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Ctr Inverness **#** 0049023 **Report Period Beginning:** 7/1/2009 **Ending:** 6/30/2010

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,645)	0	0	0	0	0	0	0	0	0	0	(3,645)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	3	(49,201)	0	0	0	0	0	0	0	0	(49,198)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,645)	3	(49,201)	0	0	0	0	0	0	0	0	(52,843)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	93,648	0	0	0	0	0	0	0	0	0	93,648	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	93,648	0	0	0	0	0	0	0	0	0	93,648	16
	C. General Administration													
17	Administrative	0	(138,000)	0	0	0	0	0	0	0	0	0	(138,000)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(13,033)	301	1,630	0	0	0	0	0	0	0	0	(11,102)	19
20	Fees, Subscriptions & Promotions	(10,934)	18	611	0	0	0	0	0	0	0	0	(10,305)	20
21	Clerical & General Office Expenses	(95,475)	102,040	742	0	0	0	0	0	0	0	0	7,307	21
22	Employee Benefits & Payroll Taxes	(40,781)	14,953	4,483	0	0	0	0	0	0	0	0	(21,345)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	3,711	2,411	0	0	0	0	0	0	0	0	6,122	24
25	Other Admin. Staff Transportation	(9,509)	2,847	3,639	0	0	0	0	0	0	0	0	(3,023)	25
26	Insurance-Prop.Liab.Malpractice	0	342	1,557	0	0	0	0	0	0	0	0	1,899	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(169,732)	(13,788)	15,073	0	0	0	0	0	0	0	0	(168,447)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(173,377)	79,863	(34,128)	0	0	0	0	0	0	0	0	(127,642)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 **Report Period Beginning:** 7/1/2009 **Ending:** 6/30/2010

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	3,528	0	0	0	0	0	0	0	0	3,528	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(52,993)	0	0	0	0	0	0	0	0	0	0	(52,993)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	86	0	0	0	0	0	0	0	0	86	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(52,993)	0	3,614	0	0	0	0	0	0	0	0	(49,379)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(226,370)	79,863	(30,514)	0	0	0	0	0	0	0	0	(177,021)	45

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if 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	See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

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

1 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	6	See Schedule VIII	$	Bravo Nursing Home Services, Inc.	100.00%	$ 3	$ 3	1
2	V	17	Management Fees	138,000	Bravo Nursing Home Services, Inc.	100.00%		(138,000)	2
3	V	19	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	301	301	3
4	V	20	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	18	18	4
5	V	21	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	102,040	102,040	5
6	V	22	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	14,953	14,953	6
7	V	24	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	3,711	3,711	7
8	V	25	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	2,847	2,847	8
9	V	26	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	342	342	9
10	V								10
11	V	10a	Therapy	765,861	Bravo Therapy Services, Inc.		859,509	93,648	11
12	V								12
13	V								13
14	Total			$ 903,861			$ 983,724	$ * 79,863	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

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

1 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)	
15	V	6	Repairs & Maintenance	$ 97,639	Bravo Senior Living Services, Inc.		$ 48,438	$ (49,201)	15
16	V	21	Clerical & Office Expenses		Bravo Senior Living Services, Inc.		742	742	16
17	V	22	Payroll Taxes & Emp Ben.		Bravo Senior Living Services, Inc.		4,483	4,483	17
18	V	24	Travel & Seminar		Bravo Senior Living Services, Inc.		2,411	2,411	18
19	V	25	Other Admin Staff Transportation		Bravo Senior Living Services, Inc.		3,639	3,639	19
20	V	26	Insurance		Bravo Senior Living Services, Inc.		873	873	20
21	V	30	Depreciation		Bravo Senior Living Services, Inc.		3,528	3,528	21
22	V	34	Rent-Facility & Grounds		Bravo Senior Living Services, Inc.		86	86	22
23	V								23
24	V								24
25	V								25
26	V	19	Professional Services		Bravo Holding Company		1,630	1,630	26
27	V	20	Dues & Subscriptions		Bravo Holding Company		611	611	27
28	V	26	Insurance		Bravo Holding Company		684	684	28
29	V								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			$ 97,639			$ 67,125	$ * (30,514)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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 L. Brady	President, Bravo	Administrative	0.00	144,555	5	7.97	Salary	$ 12,516	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	$ 12,516		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 Inverness # 0049023 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Total Cost	93,028,070	15	$ 32	$	7,412,801	$ 3	1
2	19	Professional Services	Total Cost	93,028,070	15	3,777		7,412,801	301	2
3	20	Dues & Subscriptions	Total Cost	93,028,070	15	225		7,412,801	18	3
4	21	Salaries - Other	Total Cost	93,028,070	15	1,269,110	1,269,110	7,412,801	101,127	4
5	21	Taxes, Licenses, & Office Sup	Total Cost	93,028,070	15	1,606		7,412,801	128	5
6	21	Telephone	Total Cost	93,028,070	15	9,847		7,412,801	785	6
7	22	Payroll Taxes	Total Cost	93,028,070	15	93,248		7,412,801	7,430	7
8	22	Employee Benefits	Total Cost	93,028,070	15	94,412		7,412,801	7,523	8
9	24	Travel & Seminar	Total Cost	93,028,070	15	46,571		7,412,801	3,711	9
10	25	Other Administrative Transp	Total Cost	93,028,070	15	35,723		7,412,801	2,847	10
11	26	Insurance	Total Cost	93,028,070	15	4,291		7,412,801	342	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	TOTALS					$ 1,558,842	$ 1,269,110		$ 124,215	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Schedule Not Applicable						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												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 #** _____

*** 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.)**

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 613,351	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.)		$ 678,790	2
3. Under or (over) accrual (line 2 minus line 1).		$ 65,439	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 608,472	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.		$ 673,911	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	571,308	8
	2006	581,504	9
	2007	607,278	10
	2008	633,825	11
	2009	Est. 633,825	12

2008 Payment = $330,186
2009 Payment = $348,604
Accrual = Remaining balance of 2009 tax bill ($285,221) + 1/2 estimated 2010 tax bill ($323,251)

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rosewood Care Ctr Inverness COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049023

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 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-28-301-017-0000	1800 Colonial Pky, Inverness 5-97	$ 633,208.07	$ 633,208.07
2.	02-28-301-039-0000	1800 Colonial Pky, Inverness 1-00	$ 617.18	$ 617.18
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 633,825.25	$ 633,825.25

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 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.

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 58,690 B. General Construction Type: Exterior Brick Veneer Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (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. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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

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

See Page 12A, Line 70 for total

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Building Improvements by Lessor 10/1/07-6/30/10		$	$		$	$	$	37
38	Seal and Stripe Parking Lot	2007	6,570						38
39	Replace Patio	2007	9,745						39
40	Compressors	2008	7,200						40
41	Heat Pumps	2008	2,947						41
42	Compressors	2009	4,329						42
43	Heat Pumps	2009	7,438						43
44	Exterior Doors	2009	4,554						44
45									45
46									46
47									47
48									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)		$ 42,783	$		$	$	$	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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 Depreciation (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	Bravo Senior Living Services	Various	Various	$ 14,338	$	$ 3,528	$ 3,528	4	$ 7,579	76
77										77
78										78
79										79
80	TOTALS			$ 14,338	$	$ 3,528	$ 3,528		$ 7,579	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)	$ 57,121	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 3,528	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,528	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,579	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section Not Applicable	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Section Not Applicable	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Inverness 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. [X] 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:	2000	142	10/1/07	$ 957,593	4	Unlimited	3
4	Additions							4
5								5
6	Related Party Allocation of Storage Rental				86			6
7	TOTAL		142		$ 957,679 **			7

8. List separately any amortization of lease expense included on page 4, line 34. None
   This amount was calculated by dividing the total amount to be amortized N/A
   by the length of the lease N/A .

9. Option to Buy: [ ] YES [X] NO Terms: N/A *

10. Effective dates of current rental agreement:
    Beginning 10/1/07
    Ending 9/30/11

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

	Fiscal Year Ending	Annual Rent
12.	6/30/2011	$ 1,526,940
13.	6/30/2012	$ 381,735
14.		$

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

15. Is Movable equipment rental included in building rental? [X] 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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] 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

ALLOCATION OF COSTS (d)

		1	2	3	4
		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)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a, 8	hrs	$	13,885	$ 299,649	$	13,885	$ 299,649	1
2	Licensed Speech and Language Development Therapist	10a, 8	hrs		2,494	113,404		2,494	113,404	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 8	hrs		21,764	446,456	15,296	21,764	461,752	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				374,222		374,222	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Labs, X-Rays, Enterals	39, 2 & 39, 3				33,478	18,446		51,924	12
13	Other (specify):									13
14	TOTAL			$	38,143	$ 892,987	$ 407,964	38,143	$ 1,300,951	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/2010 (last day of reporting year)

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	$ 10,495	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 80,000)	880,599		3
4	Supply Inventory (priced at Cost)	2,753		4
5	Short-Term Investments			5
6	Prepaid Insurance	12,493		6
7	Other Prepaid Expenses	46,064		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Receivables	11,660		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 964,064	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			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)**	$ 2,000	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 966,064	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 277,957	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	257,265		30
31	Accrued Taxes Payable (excluding real estate taxes)	18,119		31
32	Accrued Real Estate Taxes(Sch.IX-B)	608,472		32
33	Accrued Interest Payable	31,943		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	105,806		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,299,562	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	768,020		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)**	$ 768,020	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,067,582	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,101,518)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 966,064	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (690,205)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (690,205)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(411,313)	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)**	$ (411,313)	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)**	$ (1,101,518)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,426,454	1
2	Discounts and Allowances for all Levels	(2,251,612)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,174,842	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,819,192	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,819,192	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	2,100	13
14	Non-Patient Meals	2,107	14
15	Telephone, Television and Radio	11,432	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)**	$ 15,639	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,134	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,134	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous (See Attached)	44,175	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 44,175	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,055,982	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,183,586	31
32	Health Care	3,758,198	32
33	General Administration	1,311,888	33
	B. Capital Expense		
34	Ownership	1,709,732	34
	C. Ancillary Expense		
35	Special Cost Centers	426,146	35
36	Provider Participation Fee	77,745	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,467,295	40
41	**Income before Income Taxes (line 30 minus line 40)****	(411,313)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (411,313)	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.**

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,889	2,007	$ 76,155	$ 37.94	1
2	Assistant Director of Nursing	1,497	1,591	57,991	36.45	2
3	Registered Nurses	29,244	31,071	1,007,219	32.42	3
4	Licensed Practical Nurses	20,260	21,526	493,154	22.91	4
5	CNAs & Orderlies	62,528	66,434	830,240	12.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,113	4,370	79,681	18.23	8
9	Activity Director					9
10	Activity Assistants	5,115	5,434	67,570	12.43	10
11	Social Service Workers	3,836	4,076	60,915	14.94	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,100	22,419	222,289	9.92	15
16	Dishwashers					16
17	Maintenance Workers	2,037	2,165	28,324	13.08	17
18	Housekeepers	17,358	18,442	173,490	9.41	18
19	Laundry	5,320	5,652	47,312	8.37	19
20	Administrator	2,026	2,153	91,437	42.47	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,440	13,217	200,556	15.17	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	5,554	5,901	101,830	17.26	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	194,317	206,458	$ 3,538,163 *	$ 17.14	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Contract	$ 9,156	1, 3	35
36	Medical Director	Contract	13,050	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	5,075	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	2,388	11, 3	44
45	Social Service Consultant	Contract	3,402	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 33,071		49

C. CONTRACT NURSES

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

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Patrick Dipaolo	Administrator	0	$ 91,437
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 91,437

B. Administrative - Other

Description	Amount
Bravo Nursing Home Services	$ 138,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 138,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company	Accountant/Consultant	$ 4,110
Daniel Maher	Collections & Out of Period	12,300
Daniel Maher	Legal Fees	4,078
Midwest Administrative Services	Administrative Services	264,215
Kelly, Olsen, Michod, DeHaan & Ric	Real Estate Tax Appeal	7,305
Litchfield Cavo, LLP	Legal Fees	2,174
Old Republic Surety Group	Surety Bond	100
Alholm, Monahan, Klauke, Hay & O	Collections & Out of Period	337
Clerk of the Circuit Court of Cook C	Appearance Fees	428
Litchfield Cavo, LLP	Out of Period Legal Fees	396
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 295,443

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 84,536
Unemployment Compensation Insurance	(9,976)
FICA Taxes	263,877
Employee Health Insurance	58,656
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	4,034
Employee Uniforms	686
Related Party Allocation	19,436
TOTAL (agree to Schedule V, line 22, col.8)	$ 421,249

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
Section Not Applicable		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	2,051
Health Care Worker Background Check	3,480
(Indicate # of checks performed ____)	
IHCA Dues	5,162
Rosewood License Fee	3,000
Misc. Dues/Subscriptions	60
Promotional Advertising	7,317
Related Party Allocation	629
Less: Public Relations Expense	( )
Non-allowable advertising	(2,776)
Yellow page advertising	(4,541)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,377

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Related Party Allocation	6,122
Seminar Expense	987
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,109

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 **Report Period Beginning:** 7/1/2009 **Ending:** 6/30/2010

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 $5,162**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **None**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **63,795** 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. $ **77,745**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(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. $ **2,107**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Bravo Care of Inverness, Inc.
Attachment to Schedule VII A
6/30/2010

Name	City	Type of Business
Related Nursing Homes:		
Bravo Care of Alton, Inc.	Alton, IL	Nursing Home
Bravo Care of East Peoria Inc.	East Peoria, IL	Nursing Home
Bravo Care of Edwardsville, Inc.	Edwardsville, IL	Nursing Home
Bravo Care of Elgin, Inc.	Elgin, IL	Nursing Home
Bravo Care of Galesburg, Inc.	Galesburg, IL	Nursing Home
Bravo Care of Joliet, Inc.	Joliet, IL	Nursing Home
Bravo Care of Moline, Inc.	Moline, IL	Nursing Home
Bravo Care of Northbrook, Inc.	Northbrook, IL	Nursing Home
Bravo Care of Peoria, Inc.	Peoria, IL	Nursing Home
Bravo Care of Rockford, Inc.	Rockford, IL	Nursing Home
Bravo Care of St. Charles, Inc.	St. Charles, IL	Nursing Home
Bravo Care of St. Louis, Inc.	St. Louis, MO	Nursing Home
Other Related Business Entities:		
Bravo Care of Wood River, Inc.	Wood River, IL	Supportive Living Facility
Bravo Nursing Home Services, Inc.	St. Louis, Mo	Management Co.
Bravo Holding Company, Inc.	St. Louis, Mo	Holding Co.
Bravo Therapy Services, Inc.	St. Louis, Mo	Therapy Co.
Bravo Senior Living Services, Inc.	St. Louis, Mo	Building Services Co.
Bravo Team Health, Inc.	St. Louis, Mo	Human Resources Co.

Bravo Care of Inverness, Inc.
Attachment to Schedule XVII Line 28
6/30/2010

OTHER REVENUE:

Vendor Discounts	1,176
IL Unemployment Refund	40,781
Miscellaneous	2,218
	44,175