		FOR BHF USE					

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2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2009)

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: 208680057001

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		

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/08 to 6/30/09 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 Accountants' 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

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

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: 7/1/08 Ending: 6/30/09

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	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	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			10,158	10,158	8
9	SNF/PED					9
10	ICF	8,387	13,734		22,121	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,387	13,734	10,158	32,279	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.28%

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 10/01/07

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/01/07 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 10,158

Medicare Intermediary Palmetto GBA

IV. ACCOUNTING BASIS

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

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

Tax Year: 6/30/09 Fiscal Year: 6/30/09

* 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: 7/1/08 Ending: 6/30/09

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	225,089	23,984	9,180	258,253		258,253		258,253			1
2	Food Purchase		194,212		194,212		194,212	(5,497)	188,715			2
3	Housekeeping	171,354	48,843		220,197		220,197		220,197			3
4	Laundry	51,611	14,998		66,609		66,609		66,609			4
5	Heat and Other Utilities			220,743	220,743		220,743		220,743			5
6	Maintenance	28,487	16,659	268,351	313,497		313,497	(35,878)	277,619			6
7	Other (specify):* Garbage Removal			12,690	12,690		12,690		12,690			7
8	TOTAL General Services	476,541	298,696	510,964	1,286,201		1,286,201	(41,375)	1,244,826			8
	B. Health Care and Programs											
9	Medical Director			9,275	9,275		9,275		9,275			9
10	Nursing and Medical Records	2,614,301	192,436	6,121	2,812,858		2,812,858		2,812,858			10
10a	Therapy	76,767	7,110	789,947	873,824		873,824	96,768	970,592			10a
11	Activities	60,153	3,779	2,156	66,088		66,088		66,088			11
12	Social Services	48,021		4,030	52,051		52,051		52,051			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,799,242	203,325	811,529	3,814,096		3,814,096	96,768	3,910,864			16
	C. General Administration											
17	Administrative	92,043		138,000	230,043		230,043	(138,000)	92,043			17
18	Directors Fees											18
19	Professional Services			248,153	248,153		248,153	(6,270)	241,883			19
20	Dues, Fees, Subscriptions & Promotions			34,894	34,894	995	35,889	(8,954)	26,935			20
21	Clerical & General Office Expenses	195,580	24,832	38,570	258,982		258,982	41,441	300,423			21
22	Employee Benefits & Payroll Taxes			449,539	449,539		449,539	(1,566)	447,973			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,175	1,175	(995)	180	7,402	7,582			24
25	Other Admin. Staff Transportation			6,457	6,457		6,457	3,358	9,815			25
26	Insurance-Prop.Liab.Malpractice			26,227	26,227		26,227	3,298	29,525			26
27	Other (specify):*											27
28	TOTAL General Administration	287,623	24,832	943,015	1,255,470		1,255,470	(99,291)	1,156,179			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,563,406	526,853	2,265,508	6,355,767		6,355,767	(43,898)	6,311,869			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: 7/1/08 Ending: 6/30/09

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							3,712	3,712			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			21,651	21,651		21,651	(21,651)				32
33	Real Estate Taxes			618,027	618,027		618,027		618,027			33
34	Rent-Facility & Grounds			1,591,483	1,591,483		1,591,483		1,591,483			34
35	Rent-Equipment & Vehicles			27,123	27,123		27,123		27,123			35
36	Other (specify):*											36
37	TOTAL Ownership			2,258,284	2,258,284		2,258,284	(17,939)	2,240,345			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		339,540	46,199	385,739		385,739		385,739			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		339,540	123,944	463,484		463,484		463,484			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,563,406	866,393	4,647,736	9,077,535		9,077,535	(61,837)	9,015,698			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: 7/1/08 Ending: 6/30/09

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,606)	2		4
5	Telephone, TV & Radio in Resident Rooms	(435)	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	(482)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(409)	2		13
14	Non-Care Related Interest	(21,651)	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	(7,451)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,384)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,497)	20		28
29	Other-Attach Schedule See Attached	(114,637)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (154,552)		$	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)	92,715		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 92,715		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (61,837)		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

STATE OF ILLINOIS

Rosewood Care Ctr Inverness

ID# 0049023

Report Period Beginning: 7/1/08

Ending: 6/30/09

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Salary	$ (77,591)	21	1
2	Marketing Mileage	(5,946)	25	2
3	Worker's Comp Dividend	(27,000)	22	3
4	Lobbying & PAC Dues	(4,100)	20	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(114,637)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 Report Period Beginning: 7/1/08 Ending: 6/30/09

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	(5,497)	0	0	0	0	0	0	0	0	0	0	(5,497)	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	4	(35,882)	0	0	0	0	0	0	0	0	(35,878)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,497)	4	(35,882)	0	0	0	0	0	0	0	0	(41,375)	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	96,768	0	0	0	0	0	0	0	0	0	96,768	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	96,768	0	0	0	0	0	0	0	0	0	96,768	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	(7,451)	1,181	0	0	0	0	0	0	0	0	0	(6,270)	19
20	Fees, Subscriptions & Promotions	(8,981)	27	0	0	0	0	0	0	0	0	0	(8,954)	20
21	Clerical & General Office Expenses	(78,026)	118,053	1,414	0	0	0	0	0	0	0	0	41,441	21
22	Employee Benefits & Payroll Taxes	(27,000)	18,834	6,600	0	0	0	0	0	0	0	0	(1,566)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	3,915	3,487	0	0	0	0	0	0	0	0	7,402	24
25	Other Admin. Staff Transportation	(5,946)	3,581	5,723	0	0	0	0	0	0	0	0	3,358	25
26	Insurance-Prop.Liab.Malpractice	0	2,001	1,297	0	0	0	0	0	0	0	0	3,298	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(127,404)	9,592	18,521	0	0	0	0	0	0	0	0	(99,291)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(132,901)	106,364	(17,361)	0	0	0	0	0	0	0	0	(43,898)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 Report Period Beginning: 7/1/08 Ending: 6/30/09

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	3,712	0	0	0	0	0	0	0	0	3,712	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(21,651)	0	0	0	0	0	0	0	0	0	0	(21,651)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(21,651)	0	3,712	0	0	0	0	0	0	0	0	(17,939)	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)	(154,552)	106,364	(13,649)	0	0	0	0	0	0	0	0	(61,837)	45

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 Report Period Beginning: 7/1/08 Ending: 6/30/09

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	See Schedule VIII	$	Bravo Nursing Home Services, Inc.	100.00%	$ 4	$ 4	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%	1,181	1,181	3
4	V	20	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	27	27	4
5	V	21	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	118,053	118,053	5
6	V	22	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	18,834	18,834	6
7	V	24	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	3,915	3,915	7
8	V	25	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	3,581	3,581	8
9	V	26	See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	2,001	2,001	9
10	V								10
11	V	10a	Therapy	789,947	Bravo Therapy Services, Inc.		886,715	96,768	11
12	V								12
13	V								13
14	Total			$ 927,947			$ 1,034,311	$ * 106,364	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: 7/1/08 Ending: 6/30/09

VII. RELATED PARTIES (continued)

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

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

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Repairs & Maintenance	$ 108,012	Bravo Senior Living Services, Inc.		$ 72,130	$ (35,882)	15
16	V	21	Clerical & Office Expenses		Bravo Senior Living Services, Inc.		1,414	1,414	16
17	V	22	Payroll Taxes & Emp Ben.		Bravo Senior Living Services, Inc.		6,600	6,600	17
18	V	24	Travel & Seminar		Bravo Senior Living Services, Inc.		3,487	3,487	18
19	V	25	Other Admin Staff Transportation		Bravo Senior Living Services, Inc.		5,723	5,723	19
20	V	26	Insurance		Bravo Senior Living Services, Inc.		1,297	1,297	20
21	V	30	Depreciation		Bravo Senior Living Services, Inc.		3,712	3,712	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								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			$ 108,012			$ 94,363	$ * (13,649)	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: 7/1/08 Ending: 6/30/09

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	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Michael L . Brady	President, Bravo	Administrative	0.00	148,070	5	8.74	Salary	$ 14,180	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	$ 14,180		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: 7/1/08 Ending: 6/30/09

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	91,763,025	15	$ 43	$	8,019,925	$ 4	1
2	19	Professional Services	Total Cost	91,763,025	15	13,516		8,019,925	1,181	2
3	20	Dues & Subscriptions	Total Cost	91,763,025	15	304		8,019,925	27	3
4	21	Salaries - Other	Total Cost	91,763,025	15	1,339,568	1,339,568	8,019,925	117,076	4
5	21	Taxes, Licenses, & Office Sup	Total Cost	91,763,025	15	1,114		8,019,925	97	5
6	21	Telephone	Total Cost	91,763,025	15	10,071		8,019,925	880	6
7	22	Payroll Taxes	Total Cost	91,763,025	15	100,000		8,019,925	8,740	7
8	22	Employee Benefits	Total Cost	91,763,025	15	115,495		8,019,925	10,094	8
9	24	Travel & Seminar	Total Cost	91,763,025	15	44,792		8,019,925	3,915	9
10	25	Other Administrative Transp	Total Cost	91,763,025	15	40,970		8,019,925	3,581	10
11	26	Insurance	Total Cost	91,763,025	15	22,897		8,019,925	2,001	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					$ 1,688,770	$ 1,339,568		$ 147,596	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 Report Period Beginning: 7/1/08 Ending: 6/30/09

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	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: 7/1/08 Ending: 6/30/09

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and

1. Real Estate Tax accrual used on 2008 report.	$	450,782	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.)	$	455,458	2
3. Under or (over) accrual (line 2 minus line 1).	$	4,676	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)	$	613,351	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.	$	618,027	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
2004	517,358	8
2005	571,308	9
2006	581,504	10
2007	607,278	11
2008	Est. 607,278	12

2007 Payment = $151,819

2008 Payment = $303,639

Accrual = Remaining balance of 2008 tax bill ($303,639) + 1/2 estimated 2009 tax bill ($309,712)

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2008	$	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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2008 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2009 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2008 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 2008 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 2008.

	(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	$ 606,686.66	$ 606,686.66
2.	02-28-301-039-0000	1800 Colonial Pky, Inverness 1-00	$ 591.36	$ 591.36
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 607,278.02	$ 607,278.02

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 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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: 7/1/08 Ending: 6/30/09

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	2	3	4	
	Use	Square Feet	Year Acquired	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: 7/1/08 Ending: 6/30/09

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.

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 Report Period Beginning: 7/1/08 Ending: 6/30/09

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 10/1/07-6/30/09		$	$		$	$	$	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									42
43									43
44									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)		$ 26,462	$		$	$	$	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: 7/1/08 Ending: 6/30/09

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	$ 18,297	$	$ 3,712	$ 3,712	4 Yrs	$ 7,099	76
77										77
78										78
79										79
80	TOTALS			$ 18,297	$	$ 3,712	$ 3,712		$ 7,099	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)	$ 44,759	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)	$ 3,712	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,712	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,099	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: 7/1/08 Ending: 6/30/09

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	10/01/07	$ 1,591,483	3	Unlimited	3
4	Additions							4
5								5
6								6
7	TOTAL		142		$ 1,591,483 **			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 10/01/07
Ending 9/30/10

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

	Fiscal Year Ending	Annual Rent
12.	6/30/2010	$ 1,526,940
13.	6/30/2011	$ 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: 7/1/08 Ending: 6/30/09

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: 7/1/08 Ending: 6/30/09

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	$	16,907	$ 265,565	$	16,907	$ 265,565	1
2	Licensed Speech and Language Development Therapist	10a, 8	hrs		2,887	112,537		2,887	112,537	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 8	hrs		26,000	508,613	7,110	26,000	515,723	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				327,373		327,373	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				46,199	12,167		58,366	12
13	Other (specify):									13
14	TOTAL			$	45,794	$ 932,914	$ 346,650	45,794	$ 1,279,564	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: 7/1/08 Ending: 6/30/09

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/09 (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	$ 114,174	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 140,000)	903,317		3
4	Supply Inventory (priced at Cost)	2,870		4
5	Short-Term Investments			5
6	Prepaid Insurance	11,491		6
7	Other Prepaid Expenses	3,720		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Receivables	5,332		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,040,904	$	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)**	$ 1,042,904	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 189,785	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	237,462		30
31	Accrued Taxes Payable (excluding real estate taxes)	18,076		31
32	Accrued Real Estate Taxes(Sch.IX-B)	613,351		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	57,681		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,116,355	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	616,754		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)**	$ 616,754	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,733,109	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (690,205)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,042,904	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 Report Period Beginning: 7/1/08 Ending: 6/30/09

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (115,544)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (115,544)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(574,661)	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)**	$ (574,661)	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)**	$ (690,205)	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: 7/1/08 Ending: 6/30/09

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	$ 9,132,436	1
2	Discounts and Allowances for all Levels	(2,759,473)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,372,963	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,093,840	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,093,840	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	4,606	14
15	Telephone, Television and Radio	435	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)**	$ 7,141	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	454	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 454	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous (See Attached)	28,476	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 28,476	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,502,874	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,286,201	31
32	Health Care	3,814,096	32
33	General Administration	1,255,470	33
	B. Capital Expense		
34	Ownership	2,258,284	34
	C. Ancillary Expense		
35	Special Cost Centers	385,739	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)***	$ 9,077,535	40
41	**Income before Income Taxes (line 30 minus line 40)****	(574,661)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (574,661)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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: 7/1/08 Ending: 6/30/09

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	2,073	2,188	$ 78,071	$ 35.68	1
2	Assistant Director of Nursing	2,015	2,126	74,635	35.11	2
3	Registered Nurses	29,245	30,863	1,000,887	32.43	3
4	Licensed Practical Nurses	21,315	22,494	516,039	22.94	4
5	CNAs & Orderlies	66,418	70,090	866,635	12.36	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,731	3,938	76,767	19.49	8
9	Activity Director					9
10	Activity Assistants	5,467	5,769	60,153	10.43	10
11	Social Service Workers	3,379	3,566	48,021	13.47	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,431	22,616	225,089	9.95	15
16	Dishwashers					16
17	Maintenance Workers	2,092	2,207	28,487	12.91	17
18	Housekeepers	17,677	18,654	171,354	9.19	18
19	Laundry	6,142	6,481	51,611	7.96	19
20	Administrator	5,569	5,877	92,043	15.66	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,506	13,198	195,580	14.82	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	4,533	4,784	78,034	16.31	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	203,593	214,851	$ 3,563,406 *	$ 16.59	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Contract	$ 9,180	1, 3	35
36	Medical Director	Contract	9,275	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	5,537	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	2,156	11, 3	44
45	Social Service Consultant	Contract	4,030	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 30,178		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	0	$ 0	10-3	50
51	Licensed Practical Nurses	16	584	10-3	51
52	Certified Nurse Assistants/Aides	0	0	10-3	52
53	TOTAL (lines 50 - 52)	16	$ 584		53

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 Report Period Beginning: 7/1/08 Ending: 6/30/09

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Patrick Dipaolo	Administrator	0	$ 92,043
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 92,043

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
C. J. Schlosser & Company	Accountant/Consultant	$ 6,150
Daniel Maher	Collections & Out of Period	3,342
Daniel Maher	Legal Fees	4,919
Midwest Administrative Services	Administrative Services	227,844
Kelly, Olsen, Michod, DeHaan & Ric	Real Estate Tax Appeal	1,295
Litchfield Cavo, LLP	Out of Period Fees	3,419
Litchfield Cavo, LLP	Legal Fees	6,277
Mandell Menkes, LLC	Deductible Payments	(5,833)
Myers, Miller & Krauskopf	Out of Period Fees	255
Old Republic Surety Group	Surety Bond	50
T. Counts Burke	Collections	435
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 248,153

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 58,781
Unemployment Compensation Insurance	45,971
FICA Taxes	269,438
Employee Health Insurance	43,956
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	2,833
Employee Uniforms	250
Employee Physicals	1,310
Realted Party Allocation	25,434
TOTAL (agree to Schedule V, line 22, col.8)	$ 447,973

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	10,358
Health Care Worker Background Check	3,930
(Indicate # of checks performed)	
IHCA Dues	8,462
Rosewood License Fee	3,000
Misc. Dues/Subscriptions	163
Promotional Advertising	4,881
Related Party Allocation	27
Less: Public Relations Expense	( )
Non-allowable advertising	(1,384)
Yellow page advertising	(3,497)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,935

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Related Party Allocation	7,402
Seminar Expense	180
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,582

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 Report Period Beginning: 7/1/08 Ending: 6/30/09

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								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
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: 7/1/08 Ending: 6/30/09

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 $8,462**

(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. $ **68,099** 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. $ **4,606**

(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.

Bravo Care of Inverness, Inc.
Attachment to Schedule VII A
6/30/2009

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:		
Brave 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
6/30/2009

OTHER REVENUE:

Vendor Discounts	482
Workers Comp Dividend	27,000
Miscellaneous	994
	28,476

BRAVO CARE OF INVERNESS, INC.
RECLASSIFICATIONS
MEDICAID COST REPORT
6/30/09

	AMOUNT	LN #
A		
TRAVEL AND SEMINAR	(995)	24
DUES, FEES, SUBSCRIPTIONS & PROMOTIONS	995	20
TO RECLASS IDPH LICENSE		