



Facility Name & ID Number Rosewood Care Ctr-Edwardsville

# 0049031 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	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	120	Skilled (SNF)	120	43,800	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	120	TOTALS	120	43,800	7

**B. Census-For the entire report period.**

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			9,925	9,925	8
9	SNF/PED					9
10	ICF	7,354	13,247		20,601	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,354	13,247	9,925	30,526	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.69%**

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

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

**E. List all services provided by your facility for non-patients.**

(E.g., day care, "meals on wheels", outpatient therapy)

None

**F. Does the facility maintain a daily midnight census?**

Yes

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

YES  NO

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

YES  NO

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

Date started 10/1/07

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

YES  Date 10/1/07 NO

**K. Was the facility certified for Medicare during the reporting year?**

YES  NO  If YES, enter number

of beds certified 58 and days of care provided 9,925

Medicare Intermediary Pinnacle Business Solutions, Inc.

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

Rosewood Care Ctr-Edwardsville

# 0049031

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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	205,423	16,645	7,833	229,901		229,901		229,901		1
2	Food Purchase		159,896		159,896		159,896	(6,108)	153,788		2
3	Housekeeping	136,138	43,284		179,422		179,422		179,422		3
4	Laundry	51,125	16,801		67,926		67,926		67,926		4
5	Heat and Other Utilities			132,167	132,167		132,167		132,167		5
6	Maintenance	44,965	8,886	183,162	237,013		237,013	(40,692)	196,321		6
7	Other (specify):* <b>Garbage Collection</b>			12,341	12,341		12,341		12,341		7
8	<b>TOTAL General Services</b>	437,651	245,512	335,503	1,018,666		1,018,666	(46,800)	971,866		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			15,095	15,095		15,095		15,095		9
10	Nursing and Medical Records	2,092,151	193,061	195,305	2,480,517		2,480,517		2,480,517		10
10a	Therapy	62,573	16,901	921,453	1,000,927		1,000,927	(123,814)	877,113		10a
11	Activities	52,865	4,000	2,400	59,265		59,265		59,265		11
12	Social Services	50,912		2,400	53,312		53,312		53,312		12
13	CNA Training										13
14	Program Transportation			10	10		10		10		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,258,501	213,962	1,136,663	3,609,126		3,609,126	(123,814)	3,485,312		16
	<b>C. General Administration</b>										
17	Administrative	78,865		138,000	216,865		216,865	(138,000)	78,865		17
18	Directors Fees										18
19	Professional Services			288,253	288,253	(3,480)	284,773	(12,442)	272,331		19
20	Dues, Fees, Subscriptions & Promotions			22,577	22,577	995	23,572	(6,378)	17,194		20
21	Clerical & General Office Expenses	162,578	24,424	10,815	197,817		197,817	33,734	231,551		21
22	Employee Benefits & Payroll Taxes			379,969	379,969		379,969	1,144	381,113		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,245	2,245	(995)	1,250	5,119	6,369		24
25	Other Admin. Staff Transportation			17,150	17,150		17,150	(8,288)	8,862		25
26	Insurance-Prop.Liab.Malpractice			46,643	46,643		46,643	1,617	48,260		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	241,443	24,424	905,652	1,171,519	(3,480)	1,168,039	(123,494)	1,044,545		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,937,595	483,898	2,377,818	5,799,311	(3,480)	5,795,831	(294,108)	5,501,723		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 &amp; ID Number

Rosewood Care Ctr-Edwardsville

#0049031

Report Period Beginning:

7/1/2009

Ending:

6/30/2010

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			999	999		999	2,902	3,901			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,945	5,945		5,945	(5,945)				32
33	Real Estate Taxes			111,062	111,062	3,480	114,542		114,542			33
34	Rent-Facility & Grounds			1,165,943	1,165,943		1,165,943	70	1,166,013			34
35	Rent-Equipment & Vehicles			57,570	57,570		57,570		57,570			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,341,519	1,341,519	3,480	1,344,999	(2,973)	1,342,026			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		354,299	77,998	432,297		432,297		432,297			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		354,299	143,698	497,997		497,997		497,997			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	2,937,595	838,197	3,863,035	7,638,827		7,638,827	(297,081)	7,341,746			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer-ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,784)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(980)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(344)	2		13
14	Non-Care Related Interest	(5,945)	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	(115)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(14,133)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,192)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,511)	20		28
29	Other-Attach Schedule	(87,898)	Var.		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (118,902)		\$	30

<b>BHF USE ONLY</b>							
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	2	
		<b>Amount</b>	<b>Reference</b>	
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)	(178,179)	Var.	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (178,179)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)</b>	\$ (297,081)		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.**

		1	2	3	4	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Care Ctr-Edwardsville

ID# 0049031

Report Period Beginning: 7/1/2009

Ending: 6/30/2010

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount Reference

	Amount	Reference	Sch. V Line
1 Eliminate Marketing Salary	\$ (56,257)	21	1
2 Eliminate Marketing Mileage	(13,774)	25	2
3 Offset IL Unemployment Refund	(15,641)	22	3
4 Eliminate Lobbying & PAC Dues	(2,226)	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	(87,898)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Ctr-Edwardsville# 0049031

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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,108)	0	0	0	0	0	0	0	0	0	0	(6,108)	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	2	(40,694)	0	0	0	0	0	0	0	0	(40,692)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(6,108)</b>	<b>2</b>	<b>(40,694)</b>	<b>0</b>	<b>(46,800)</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
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	(123,814)	0	0	0	0	0	0	0	0	0	(123,814)	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>(123,814)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(123,814)</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(14,133)	264	1,427	0	0	0	0	0	0	0	0	(12,442)	19
20	Fees, Subscriptions & Promotions	(6,929)	16	535	0	0	0	0	0	0	0	0	(6,378)	20
21	Clerical & General Office Expenses	(56,257)	89,380	611	0	0	0	0	0	0	0	0	33,734	21
22	Employee Benefits & Payroll Taxes	(15,641)	13,098	3,687	0	0	0	0	0	0	0	0	1,144	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(115)	3,251	1,983	0	0	0	0	0	0	0	0	5,119	24
25	Other Admin. Staff Transportation	(13,774)	2,493	2,993	0	0	0	0	0	0	0	0	(8,288)	25
26	Insurance-Prop.Liab.Malpractice	0	300	1,317	0	0	0	0	0	0	0	0	1,617	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(106,849)</b>	<b>(29,198)</b>	<b>12,553</b>	<b>0</b>	<b>(123,494)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(112,957)</b>	<b>(153,010)</b>	<b>(28,141)</b>	<b>0</b>	<b>(294,108)</b>	<b>29</b>							

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Ctr-Edwardsville# 0049031

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)
	<b>D. Ownership</b>												
30	Depreciation	0	0	2,902	0	0	0	0	0	0	0	0	2,902 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(5,945)	0	0	0	0	0	0	0	0	0	0	(5,945) 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	70	0	0	0	0	0	0	0	0	70 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	<b>TOTAL Ownership</b>	<b>(5,945)</b>	<b>0</b>	<b>2,972</b>	<b>0</b>	<b>(2,973) 37</b>							
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0 44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(118,902)</b>	<b>(153,010)</b>	<b>(25,169)</b>	<b>0</b>	<b>(297,081) 45</b>							

**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
<u>Bravo Services, L.L.C.</u>	<u>100</u>	<u>See Attached</u>		<u>See Attached</u>		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	6		<u>Bravo Nursing Home Services, Inc.</u>	<u>100.00%</u>	\$ <u>2</u>	\$ <u>2</u>	<u>1</u>
2	V	17	<u>138,000</u>	<u>Bravo Nursing Home Services, Inc.</u>	<u>100.00%</u>		<u>(138,000)</u>	<u>2</u>
3	V	19		<u>Bravo Nursing Home Services, Inc.</u>	<u>100.00%</u>	<u>264</u>	<u>264</u>	<u>3</u>
4	V	20		<u>Bravo Nursing Home Services, Inc.</u>	<u>100.00%</u>	<u>16</u>	<u>16</u>	<u>4</u>
5	V	21		<u>Bravo Nursing Home Services, Inc.</u>	<u>100.00%</u>	<u>89,380</u>	<u>89,380</u>	<u>5</u>
6	V	22		<u>Bravo Nursing Home Services, Inc.</u>	<u>100.00%</u>	<u>13,098</u>	<u>13,098</u>	<u>6</u>
7	V	24		<u>Bravo Nursing Home Services, Inc.</u>	<u>100.00%</u>	<u>3,251</u>	<u>3,251</u>	<u>7</u>
8	V	25		<u>Bravo Nursing Home Services, Inc.</u>	<u>100.00%</u>	<u>2,493</u>	<u>2,493</u>	<u>8</u>
9	V	26		<u>Bravo Nursing Home Services, Inc.</u>	<u>100.00%</u>	<u>300</u>	<u>300</u>	<u>9</u>
10	V							<u>10</u>
11	V	10a	<u>921,453</u>	<u>Bravo Therapy Services, Inc.</u>		<u>797,639</u>	<u>(123,814)</u>	<u>11</u>
12	V							<u>12</u>
13	V							<u>13</u>
14	Total		\$ <u>1,059,453</u>			\$ <u>906,443</u>	\$ * <u>(153,010)</u>	<u>14</u>

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr-Edwardsville# 0049031Report Period Beginning: 7/1/2009Ending: 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.  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 <u>Repairs &amp; Maintenance</u>	\$ 80,305	<u>Bravo Senior Living Services, Inc.</u>		\$ 39,611	\$ (40,694)
16	V	21 <u>Clerical &amp; Office Expenses</u>		<u>Bravo Senior Living Services, Inc.</u>		611	611
17	V	22 <u>Payroll Taxes &amp; Emp Ben.</u>		<u>Bravo Senior Living Services, Inc.</u>		3,687	3,687
18	V	24 <u>Travel &amp; Seminar</u>		<u>Bravo Senior Living Services, Inc.</u>		1,983	1,983
19	V	25 <u>Other Admin Staff Transportation</u>		<u>Bravo Senior Living Services, Inc.</u>		2,993	2,993
20	V	26 <u>Insurance</u>		<u>Bravo Senior Living Services, Inc.</u>		718	718
21	V	30 <u>Depreciation</u>		<u>Bravo Senior Living Services, Inc.</u>		2,902	2,902
22	V	34 <u>Rent-Facility &amp; Grounds</u>		<u>Bravo Senior Living Services, Inc.</u>		70	70
23	V						
24	V						
25	V	19 <u>Professional Services</u>		<u>Bravo Holding Company</u>		1,427	1,427
26	V	20 <u>Dues &amp; Subscriptions</u>		<u>Bravo Holding Company</u>		535	535
27	V	26 <u>Insurance</u>		<u>Bravo Holding Company</u>		599	599
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 80,305			\$ 55,136	\$ * (25,169)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

Rosewood Care Ctr-Edwardsville

#

0049031

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 Brady	President, Bravo	Administrative	0.00	146,108	4	6.98	Salary	\$ 10,963	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	\$ 10,963		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr-Edwardsville

# 0049031

Report Period Beginning: 7/1/2009

7/1/2009

Ending: 5/30/2010

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  NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Bravo Nursing Home Services  
 Street Address 11701 Borman Drive, Suite 315  
 City / State / Zip Code St. Louis, MO 63146  
 Phone Number (314) 994-9070  
 Fax Number (314) 994-9912

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Total Cost	15	\$ 32	\$	6,493,124	\$ 2	1
2	19	Professional Services	Total Cost	15	3,777		6,493,124	264	2
3	20	Dues & Subscriptions	Total Cost	15	225		6,493,124	16	3
4	21	Salaries - Other	Total Cost	15	1,269,110	1,269,110	6,493,124	88,581	4
5	21	Taxes, Licenses & Office Supplies	Total Cost	15	1,606		6,493,124	112	5
6	21	Telephone	Total Cost	15	9,847		6,493,124	687	6
7	22	Payroll Taxes	Total Cost	15	93,248		6,493,124	6,508	7
8	22	Employee Benefits	Total Cost	15	94,412		6,493,124	6,590	8
9	24	Travel & Seminar	Total Cost	15	46,571		6,493,124	3,251	9
10	25	Administrative Transportation	Total Cost	15	35,723		6,493,124	2,493	10
11	26	Insurance	Total Cost	15	4,291		6,493,124	300	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		\$ 108,804	25

SEE ACCOUNTANTS' COMPILATION REPORT

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10										
										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			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	<b>Section Not Applicable</b>																		
2																			
3																			
4																			
5																			
<b>Working Capital</b>																			
6																			
7																			
8																			
9	<b>TOTAL Facility Related</b>																		
<b>B. Non-Facility Related*</b>																			
10																			
11																			
12																			
13																			
14	<b>TOTAL Non-Facility Related</b>																		
15	<b>TOTALS (line 9+line14)</b>																		

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.)

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

**B. Real Estate Taxes**

**Important, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2009 report.		\$	<u>153,343</u>	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.)		\$	<u>129,276</u>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>(24,067)</u>	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>142,089</u>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	<u>3,480</u>	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. <b>TOTAL REFUND \$ <u>6,960</u> For <u>2007</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	<u>(6,960)</u>	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>114,542</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2005	<u>93,084</u>	8
	2006	<u>99,072</u>	9
	2007	<u>106,467</u>	10
	2008	<u>101,552</u>	11
	2009	<u>112,770</u>	12

**2008 Payment = \$101,083 + 2009 Payment = \$28,193**

**Accrual = Balance of 2009 tax bill (\$84,577) + 1/2 of estimated 2010 tax bill (\$57,512)**

	<b>FOR BHF USE ONLY</b>		
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



Facility Name & ID Number Rosewood Care Ctr-Edwardsville

# 0049031

Report Period Beginning:

7/1/2009

Ending:

6/30/2010

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 39,200 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  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	<u>Schedule N/A</u>			\$	1
2					2
3	<b>TOTALS</b>			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Wallpaper for 37 guest rooms		2008		6,993	999	7	999		2,331	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

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 <b>Building Improvements made by Lessor 10/1/07-6/30/10</b>		\$	\$		\$	\$	\$	37
38 <b>Wall Repair</b>	2010	9,158						38
39 <b>Sprinkler System</b>	2010	7,634						39
40 <b>Plumbing</b>	2010	3,308						40
41 <b>Locks and Keys</b>	2010	2,541						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 <b>TOTAL (lines 4 thru 69)</b>		\$ 29,634	\$ 999		\$ 999	\$	\$ 2,331	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-Edwardsville

# 0049031

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	\$ <u>Section Not Applicable</u>	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	<b>TOTALS</b>	\$	\$	\$	\$		\$	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	<u>Bravo Senior Living Services</u>	<u>Various</u>	<u>Various</u>	\$ <u>11,793</u>	\$	\$ <u>2,902</u>	\$ <u>2,902</u>	<u>4</u>	\$ <u>6,234</u>	76
77										77
78										78
79										79
80	<b>TOTALS</b>			\$ <u>11,793</u>	\$	\$ <u>2,902</u>	\$ <u>2,902</u>		\$ <u>6,234</u>	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)	\$ <u>41,427</u>	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ <u>999</u>	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ <u>3,901</u>	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ <u>2,902</u>	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ <u>8,565</u>	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	<u>Section Not Applicable</u>	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	<b>TOTALS</b>	\$	\$	\$	91

**G. Construction-in-Progress**

	Description	Cost	
92	<u>Section Not Applicable</u>	\$	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-Edwardsville

STATE OF ILLINOIS

# 0049031

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: Edwardsville Real Estate, L.L.C.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1995	120	10/01/07	\$ 1,165,943	4	Unlimited	3
4	Additions							4
5								5
6	Related Party Allocation of Storage Rental				70			6
7	TOTAL		120		\$ 1,166,013			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A.

None  
N/A

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ Not Specified Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

10. Effective dates of current rental agreement:

Beginning 10/1/07

Ending 6/30/11

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

Fiscal Year Ending Annual Rent

12. 6/30/2011 \$ 1,052,400

13. \_\_\_\_\_ \$ \_\_\_\_\_

14. \_\_\_\_\_ \$ \_\_\_\_\_

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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.)**

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
  - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a, 8	hrs	\$	19,754	\$ 357,623	\$	19,754	\$ 357,623	1
2	Licensed Speech and Language Development Therapist	10a, 8	hrs		3,574	52,955		3,574	52,955	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 8	hrs		24,049	387,061	16,901	24,049	403,962	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 prescripts				337,161		337,161	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Labs, X-Rays, Enterals</u>	39, 2 & 39, 3				77,998	17,138		95,136	12
13	Other (specify):									13
14	<b>TOTAL</b>			\$	47,377	\$ 875,637	\$ 371,200	47,377	\$ 1,246,837	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-Edwardsville# 0049031Report 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	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 15,302	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 50,000 )	908,187		3
4	Supply Inventory (priced at Cost )	2,426		4
5	Short-Term Investments			5
6	Prepaid Insurance	1,481		6
7	Other Prepaid Expenses	3,434		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Receivables</u>	52,833		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 983,663	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	6,993		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(2,331)		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): <u>Deposits</u>	2,467		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 7,129	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 990,792	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 270,266	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	193,704		30
31	Accrued Taxes Payable (excluding real estate taxes)	16,463		31
32	Accrued Real Estate Taxes(Sch.IX-B)	142,089		32
33	Accrued Interest Payable	2,282		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Accrued Expenses</u>	95,141		36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 719,945	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	52,546		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 52,546	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 772,491	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 218,301	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 990,792	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>200,029</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>200,029</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>18,272</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>18,272</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>218,301</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 7,926,464	1
2	Discounts and Allowances for all Levels	(2,450,999)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 5,475,465</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,150,373	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 2,150,373</b>	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,400	13
14	Non-Patient Meals	4,784	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 7,184</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	6,268	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 6,268</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous (See Attached)</u>	17,809	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 17,809</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 7,657,099</b>	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,018,666	31
32	Health Care	3,609,126	32
33	General Administration	1,171,519	33
<b>B. Capital Expense</b>			
34	Ownership	1,341,519	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	432,297	35
36	Provider Participation Fee	65,700	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 7,638,827</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>18,272</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 18,272</b>	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-Edwardsville

# 0049031

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	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,026	2,131	\$ 69,996	\$ 32.85	1
2	Assistant Director of Nursing	1,978	2,081	59,086	28.39	2
3	Registered Nurses	25,130	26,442	751,198	28.41	3
4	Licensed Practical Nurses	19,599	20,622	439,529	21.31	4
5	CNAs & Orderlies	61,546	64,759	708,762	10.94	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,719	3,913	62,573	15.99	8
9	Activity Director					9
10	Activity Assistants	4,872	5,126	52,865	10.31	10
11	Social Service Workers	4,021	4,231	50,912	12.03	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,175	21,229	205,423	9.68	15
16	Dishwashers					16
17	Maintenance Workers	2,290	2,410	44,965	18.66	17
18	Housekeepers	13,927	14,654	136,138	9.29	18
19	Laundry	4,926	5,183	51,125	9.86	19
20	Administrator	2,006	2,111	78,865	37.36	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,308	11,899	162,578	13.66	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	3,799	3,997	63,580	15.91	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	181,322	190,788	\$ 2,937,595 *	\$ 15.40	34

\* 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	\$ 7,833	1, 3	35
36	Medical Director	Contract	15,095	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	4,774	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Contract	2,400	11, 3	44
45	Social Service Consultant	Contract	2,400	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 32,502		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	783	\$ 34,072	10-3	50
51	Licensed Practical Nurses	1,834	55,271	10-3	51
52	Certified Nurse Assistants/Aides	5,397	101,188	10-3	52
53	TOTAL (lines 50 - 52)	8,014	\$ 190,531		53

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Rosewood Care Ctr-Edwardsville

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

SEE ACCOUNTANTS' COMPILATION REPORT

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IHCA \$4,388
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 60,258 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES  X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO  X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 65,700  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 4,784
- (16) Travel and Transportation
  - a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
  - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
  - c. What percent of all travel expense relates to transportation of nurses and patients? N/A
  - d. Have vehicle usage logs been maintained?
  - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
  - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
  - g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

**SEE ACCOUNTANTS' COMPILATION REPORT**

Bravo Care of Edwardsville, 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 Elgin, Inc.	Elgin, IL	Nursing Home
Bravo Care of Galesburg, Inc.	Galesburg, IL	Nursing Home
Bravo Care of Inverness, Inc.	Inverness, 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 Edwardsville, Inc.  
Attachment to Schedule XVII Line 28  
6/30/2010

OTHER REVENUE:

Vendor Discounts	980
IL Unemployment Refund	15,641
Miscellaneous	<u>1,188</u>
	<u><u>17,809</u></u>