FOR BHF USE

LL1

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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0049031

Facility Name: Rosewood Cr Ctr Edwardsville

Address: 6277 Center Grove Rd (Number) Edwardsville (City) 62025 (Zip Code)

County: Madison

Telephone Number: (618)569-0605 **Fax #** (618)659-0627

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Larry Templin **Telephone Number:** (630) 361-2868
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2014 to 06/30/2015 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) Jack McKittrick
(Title) Chief Financial Officer

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, P.O. Box 9, Dunlap, IL 61525
(Telephone) (630) 361-2868 Fax # ( )

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 Cr Ctr Edwardsville # 0049031 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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 N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	16,214	13,722	5,188	35,124	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,214	13,722	5,188	35,124	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.19%

D. How many bed-hold days during this year were paid by the Department?
None (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] Non-allowable costs have been eliminated in Schedule V, Column 7

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 12/01/2007

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/01/2007 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 3,644

Medicare Intermediary Novitas Solutions, Inc.

IV. ACCOUNTING BASIS

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

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

Tax Year: 6/30/2015 Fiscal Year: 6/30/2015

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Cr Ctr Edwardsville # 0049031 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	221,262	22,311	7,315	250,888		250,888	4,669	255,557			1
2	Food Purchase		219,211		219,211		219,211	(5,409)	213,802			2
3	Housekeeping	21,873	13,656	155,524	191,053		191,053		191,053			3
4	Laundry	6,239	9,811	103,683	119,733		119,733		119,733			4
5	Heat and Other Utilities			123,588	123,588		123,588	468	124,056			5
6	Maintenance	47,746	3,289	217,511	268,546		268,546	(38,793)	229,753			6
7	Other (specify):* Allocated HO Benefits							4,987	4,987			7
8	TOTAL General Services	297,120	268,278	607,621	1,173,019		1,173,019	(34,078)	1,138,941			8
	B. Health Care and Programs											
9	Medical Director			21,600	21,600		21,600		21,600			9
10	Nursing and Medical Records	2,631,647	194,107	16,004	2,841,758		2,841,758	52,494	2,894,252			10
10a	Therapy		1,872	813,776	815,648		815,648		815,648			10a
11	Activities	47,426	2,598	1,800	51,824		51,824		51,824			11
12	Social Services	55,404		1,800	57,204		57,204		57,204			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Allocated HO Benefits							5,569	5,569			15
16	TOTAL Health Care and Programs	2,734,477	198,577	854,980	3,788,034		3,788,034	58,063	3,846,097			16
	C. General Administration											
17	Administrative	88,106		351,216	439,322		439,322	(290,698)	148,624			17
18	Directors Fees											18
19	Professional Services			130,519	130,519		130,519	181,618	312,137			19
20	Dues, Fees, Subscriptions & Promotions			13,167	13,167		13,167	5,266	18,433			20
21	Clerical & General Office Expenses	83,363	19,014	148,044	250,421		250,421	187,500	437,921			21
22	Employee Benefits & Payroll Taxes			480,625	480,625		480,625		480,625			22
23	Inservice Training & Education											23
24	Travel and Seminar			110	110		110	10,549	10,659			24
25	Other Admin. Staff Transportation			16,441	16,441		16,441	(6,782)	9,659			25
26	Insurance-Prop.Liab.Malpractice			43,816	43,816		43,816	14,393	58,209			26
27	Other (specify):* Allocated HO Benefits							26,866	26,866			27
28	TOTAL General Administration	171,469	19,014	1,183,938	1,374,421		1,374,421	128,712	1,503,133			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,203,066	485,869	2,646,539	6,335,474		6,335,474	152,697	6,488,171			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 Cr Ctr Edwardsville #0049031 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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			11,812	11,812		11,812	89,322	101,134			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			138,454	138,454		138,454	249,029	387,483			32
33	Real Estate Taxes							85,326	85,326			33
34	Rent-Facility & Grounds			1,097,634	1,097,634		1,097,634	(1,084,999)	12,635			34
35	Rent-Equipment & Vehicles			19,046	19,046		19,046	2,241	21,287			35
36	Other (specify):* Mortgage Ins.							27,193	27,193			36
37	TOTAL Ownership			1,266,946	1,266,946		1,266,946	(631,888)	635,058			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		188,419		188,419		188,419		188,419			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			252,116	252,116		252,116		252,116			42
43	Other (specify):* See Att Sch 4A	89,289		222,354	311,643		311,643	(275,936)	35,707			43
44	TOTAL Special Cost Centers	89,289	188,419	474,470	752,178		752,178	(275,936)	476,242			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,292,355	674,288	4,387,955	8,354,598		8,354,598	(755,127)	7,599,471			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

Rosewood Cr Ctr Edwardsville

Period Beginning 07/01/2014
Period End 06/30/2015

Schedule 4A

V. Cost Center Expenses

		Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	Ancillary Expense											
	E. Special Cost Centers											
43	Other (specify):*				0		0		0			
	Laboratory/OP Expenses			22,787	22,787		22,787		22,787			
	Radiology Expenses			12,920	12,920		12,920		12,920			
	Non-Allowable Expenses	89,289		186,647	275,936		275,936	(275,936)	0			
					0		0		0			
					0		0		0			
	TOTAL Other Special Cost Centers	89,289	0	222,354	311,643	0	311,643	(275,936)	35,707			

Facility Name & ID Number Rosewood Cr Ctr Edwardsville # 0049031 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,784)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,267)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(81,758)	30		9
10	Interest and Other Investment Income	(3,621)	32		10
11	Discounts, Allowances, Rebates & Refunds	(2,626)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(28)	43		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,627)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(173,118)	43		24
25	Fund Raising, Advertising and Promotional	(4,610)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(418)	43		28
29	Other-Attach Schedule See Page 5A	(113,691)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (392,548)		$	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)	(362,579)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (362,579)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (755,127)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Cr Ctr Edwardsville

ID# 0049031

Report Period Beginning: 07/01/2014

Ending: 06/30/2015

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate Marketing Salary	$ (89,289)	43	1
2	Eliminate Lobbying & PAC Dues	(2,949)	20	2
3	Miscellaneous Income Offset	640	21	3
4	Resident Reimbursements	(206)	43	4
5	Management Fee-Real Estate Entity	(7,200)	17	5
6	Mileage Reimbursement Related to Marketing	(14,687)	25	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**	(113,691)		49

Facility Name & ID Number Rosewood Cr Ctr Edwardsville # 0049031 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Bravo Services, L.L.C.	100	See Page 6 - Supplemental		See Page 6 - Supplemental		

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Bravo Nursing Home Services, Inc.	0.00%	$ 839	$ 839	1
2	V	6	Maintenance		Bravo Nursing Home Services, Inc.	0.00%	30	30	2
3	V	7	Mgmt. Allocation of Benefits		Bravo Nursing Home Services, Inc.	0.00%	89	89	3
4	V	10	Nursing & Medical Records		Bravo Nursing Home Services, Inc.	0.00%	41,975	41,975	4
5	V	15	Mgmt. Allocation of Benefits		Bravo Nursing Home Services, Inc.	0.00%	4,459	4,459	5
6	V	17	Administrative	138,000	Bravo Nursing Home Services, Inc.	0.00%	15,255	(122,745)	6
7	V	19	Professional Services		Bravo Nursing Home Services, Inc.	0.00%	118	118	7
8	V	20	Dues, Fees, Subs & Promotions		Bravo Nursing Home Services, Inc.	0.00%	59	59	8
9	V	21	Clerical and General Office		Bravo Nursing Home Services, Inc.	0.00%	50,716	50,716	9
10	V	24	Travel and Seminar		Bravo Nursing Home Services, Inc.	0.00%	2,273	2,273	10
11	V	25	Other Admin. Staff Transport.		Bravo Nursing Home Services, Inc.	0.00%	2,008	2,008	11
12	V	26	Insurance-Prop./Liab./Malprac.		Bravo Nursing Home Services, Inc.	0.00%	220	220	12
13	V	27	Mgmt. Allocation of Benefits		Bravo Nursing Home Services, Inc.	0.00%	6,873	6,873	13
14	Total			$ 138,000			$ 124,914	$ * (13,086)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Cr Ctr Edwardsville # 0049031 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Midwest Administrative Services, Inc.	0.00%	$ 3,830	$ 3,830	15
16	V	2	Food		Midwest Administrative Services, Inc.	0.00%	1	1	16
17	V	5	Utilities		Midwest Administrative Services, Inc.	0.00%	152	152	17
18	V	6	Maintenance		Midwest Administrative Services, Inc.	0.00%	1,162	1,162	18
19	V	7	Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	404	404	19
20	V	10	Nursing and Medical Records		Midwest Administrative Services, Inc.	0.00%	10,519	10,519	20
21	V	15	Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	1,110	1,110	21
22	V	17	Administrative	213,216	Midwest Administrative Services, Inc.	0.00%	45,263	(167,953)	22
23	V	19	Professional Services		Midwest Administrative Services, Inc.	0.00%	8,052	8,052	23
24	V	20	Dues, Fees, Subs & Promotions		Midwest Administrative Services, Inc.	0.00%	7,539	7,539	24
25	V	21	Clerical and General Office	61,107	Midwest Administrative Services, Inc.	0.00%	166,792	105,685	25
26	V	24	Travel and Seminar		Midwest Administrative Services, Inc.	0.00%	3,522	3,522	26
27	V	25	Other Admin. Staff Transport.		Midwest Administrative Services, Inc.	0.00%	2,005	2,005	27
28	V	26	Insurance-Prop./Liab./Malprac.		Midwest Administrative Services, Inc.	0.00%	4,053	4,053	28
29	V	27	Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	18,149	18,149	29
30	V	30	Depreciation		Midwest Administrative Services, Inc.	0.00%	17,009	17,009	30
31	V	32	Interest		Midwest Administrative Services, Inc.	0.00%	13,558	13,558	31
32	V	34	Rent-Facility and Grounds		Midwest Administrative Services, Inc.	0.00%	12,635	12,635	32
33	V	35	Rent-Equipment & Vehicles		Midwest Administrative Services, Inc.	0.00%	2,241	2,241	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 274,323			$ 317,996	$ * 43,673	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Cr Ctr Edwardsville # 0049031 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Services	$ 9,144	Claims Administration Services, LLC	0.00%	$ 297	$ (8,847)	15
16	V	21	Clerical and General Office		Claims Administration Services, LLC	0.00%	17,154	17,154	16
17	V	24	Travel and Seminar		Claims Administration Services, LLC	0.00%	989	989	17
18	V	25	Other Admin. Staff Transport.		Claims Administration Services, LLC	0.00%	518	518	18
19	V	26	Insurance-Prop./Liab./Malprac.		Claims Administration Services, LLC	0.00%	220	220	19
20	V	27	Mgmt. Allocation of Benefits		Claims Administration Services, LLC	0.00%	1,844	1,844	20
21	V								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			$ 9,144			$ 21,022	$ * 11,878	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Cr Ctr Edwardsville # 0049031 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	Senior Living Services, Inc.	0.00%	$ 316	$ 316	15
16	V	6	Maintenance	77,520	Senior Living Services, Inc.	0.00%	37,535	(39,985)	16
17	V	7	Mgmt. Allocation of Benefits		Senior Living Services, Inc.	0.00%	4,494	4,494	17
18	V	19	Professional Services		Senior Living Services, Inc.	0.00%	9	9	18
19	V	21	Clerical and General Office		Senior Living Services, Inc.	0.00%	773	773	19
20	V	24	Travel and Seminar		Senior Living Services, Inc.	0.00%	3,467	3,467	20
21	V	25	Other Admin. Staff Transport.		Senior Living Services, Inc.	0.00%	3,068	3,068	21
22	V	26	Insurance-Prop./Liab./Malprac.		Senior Living Services, Inc.	0.00%	905	905	22
23	V	30	Depreciation		Senior Living Services, Inc.	0.00%	1,245	1,245	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			$ 77,520			$ 51,812	$ * (25,708)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Cr Ctr Edwardsville # 0049031 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Services	$	Bravo Holding Company	0.00%	$ 177,787	$ 177,787	15
16	V	20	Fees & Subscriptions		Bravo Holding Company	0.00%	67	67	16
17	V	21	Clerical and General Office		Bravo Holding Company	0.00%	908	908	17
18	V	24	Travel and Seminar		Bravo Holding Company	0.00%	298	298	18
19	V	25	Other Admin. Staff Transport.		Bravo Holding Company	0.00%	306	306	19
20	V	26	Insurance-Prop./Liab./Malprac.		Bravo Holding Company	0.00%	726	726	20
21	V	32	Interest	94,246	Bravo Holding Company	0.00%	19,112	(75,134)	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			$ 94,246			$ 199,204	$ * 104,958	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Cr Ctr Edwardsville # 0049031 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Administrative	$	Edwardsville Real Estate, LLC	0.00%	$ 7,200	$ 7,200	15
16	V	19	Professional Services		Edwardsville Real Estate, LLC	0.00%	6,126	6,126	16
17	V	20	Dues & Subscriptions		Edwardsville Real Estate, LLC	0.00%	550	550	17
18	V	21	Clerical and General Office		Edwardsville Real Estate, LLC	0.00%	11,624	11,624	18
19	V	26	Insurance-Prop./Liab./Malprac.		Edwardsville Real Estate, LLC	0.00%	8,269	8,269	19
20	V	30	Depreciation		Edwardsville Real Estate, LLC	0.00%	152,826	152,826	20
21	V	32	Interest	32	Edwardsville Real Estate, LLC	0.00%	314,258	314,226	21
22	V	33	Real Estate Taxes		Edwardsville Real Estate, LLC	0.00%	85,326	85,326	22
23	V	34	Rent-Facility and Grounds	1,097,634	Edwardsville Real Estate, LLC	0.00%		(1,097,634)	23
24	V	36	Mortgage Insurance		Edwardsville Real Estate, LLC	0.00%	27,193	27,193	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			$ 1,097,666			$ 613,372	$ * (484,294)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Cr Ctr Edwardsville # 0049031 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2			Bravo Care of Alton, Inc.	Alton, IL	Bravo Care of Wood		Supportive Living	2
3			Bravo Care of East Peoria, Inc.	East Peoria, IL	River, Inc.	Wood River, IL	Facility	3
4			Bravo Care of Elgin, Inc.	Elgin, IL	Bravo Nursing Home			4
5			Bravo Care of Galeburg, Inc.	Galesburg, IL	Services, Inc.	St. Louis, MO	Management Co.	5
6			Bravo Care of Inverness, Inc.	Inverness, IL	Bravo Holding			6
7			Bravo Care of Joliet, Inc.	Joliet, IL	Company, Inc.	St. Louis, MO	Holding Co.	7
8			Bravo Care of Moline, Inc.	Moline, IL	Senior Living		Building Services	8
9			Bravo Care of Northbrook, Inc.	Northbrook, IL	Services, Inc.	St. Louis, MO	Company	9
10			Bravo Care of Peoria, Inc.	Peoria, IL	Bravo Team		Human Resources	10
11			Bravo Care of Rockford, Inc.	Rockford, IL	Health, Inc.	St. Louis, MO	Company	11
12			Bravo Care of St. Charles, Inc.	St. Charles, IL	Claims Administration		Legal Services	12
13			Bravo Care of St. Louis, Inc.	St. Louis, MO	Services, LLC	St. Louis, MO		13
14					Edwardsville Real			14
15					Estate, LLC	Edwardsville, IL	Lessor	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Cr Ctr Edwardsville # 0049031 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Yampol	CEO	Administrative	0.00	56,435	4.97	9.94	Salary	4,555	L17, C7	1
2	Mark Yampol	CEO	Administrative	0.00	1,387,971	See Above	See Above	Consulting	112,029	L19, C7	2
3	Hillel Yampol	Owner	Administrative	0.00	44,543	4.97	9.94	Salary	3,595	L17, C7	3
4	Christene Rene Yampol	Owner	Administrative	0.00	64,852	4.97	9.94	Salary	7,158	L17, C7	4
5											5
6	See Attached Schedule 7A										6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 127,337		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 Cr Ctr Edwardsville # 0049031 Report Period Beginning: 07/01/2014 Ending: 6/30/2015

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	1	Dietary	WeightedCensus	470,290	14	11,239	11,239	35,124	$ 839	1
2	6	Maintenance	WeightedCensus	470,290	14	397		35,124	30	2
3	7	Mgmt. Allocation of Benefits	WeightedCensus	470,290	14	1,193		35,124	89	3
4	10	Nursing & Medical Records	WeightedCensus	470,290	14	562,016	562,016	35,124	41,975	4
5	15	Mgmt. Allocation of Benefits	WeightedCensus	470,290	14	59,699		35,124	4,459	5
6	17	Administrative	WeightedCensus	470,290	14	204,253	204,253	35,124	15,255	6
7	19	Professional Services	WeightedCensus	470,290	14	1,579		35,124	118	7
8	20	Dues, Fees, Subs & Promotions	WeightedCensus	470,290	14	786		35,124	59	8
9	21	Clerical and General Office	WeightedCensus	470,290	14	679,056	662,076	35,124	50,716	9
10	24	Travel and Seminar	WeightedCensus	470,290	14	30,438		35,124	2,273	10
11	25	Other Admin. Staff Transport.	WeightedCensus	470,290	14	26,889		35,124	2,008	11
12	26	Insurance-Prop./Liab./Malprac.	WeightedCensus	470,290	14	2,943		35,124	220	12
13	27	Mgmt. Allocation of Benefits	WeightedCensus	470,290	14	92,023		35,124	6,873	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					$ 1,672,511	$ 1,439,584		$ 124,914	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Cr Ctr Edwardsville # 0049031 Report Period Beginning: 07/01/2014 Ending: 6/30/2015

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: Midwest Administrative Services, Inc.
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	1	Dietary	WeightedCensus	470,290	14	51,283	51,283	35,124	$ 3,830	1
2	2	Food	WeightedCensus	470,290	14	13		35,124	1	2
3	5	Utilities	WeightedCensus	470,290	14	2,032		35,124	152	3
4	6	Maintenance	WeightedCensus	470,290	14	15,554		35,124	1,162	4
5	7	Mgmt. Allocation of Benefits	WeightedCensus	470,290	14	5,409		35,124	404	5
6	10	Nursing and Medical Records	WeightedCensus	470,290	14	140,839	140,839	35,124	10,519	6
7	15	Mgmt. Allocation of Benefits	WeightedCensus	470,290	14	14,860		35,124	1,110	7
8	17	Administrative	WeightedCensus	470,290	14	606,045	606,045	35,124	45,263	8
9	19	Professional Services	WeightedCensus	470,290	14	107,816		35,124	8,052	9
10	20	Dues, Fees, Subs & Promotions	WeightedCensus	470,290	14	100,942		35,124	7,539	10
11	21	Clerical and General Office	WeightedCensus	470,290	14	2,233,257	1,697,067	35,124	166,792	11
12	24	Travel and Seminar	WeightedCensus	470,290	14	47,164		35,124	3,522	12
13	25	Other Admin. Staff Transport.	WeightedCensus	470,290	14	26,845		35,124	2,005	13
14	26	Insurance-Prop./Liab./Malprac.	WeightedCensus	470,290	14	54,274		35,124	4,053	14
15	27	Mgmt. Allocation of Benefits	WeightedCensus	470,290	14	243,011		35,124	18,149	15
16	30	Depreciation	WeightedCensus	470,290	14	227,745		35,124	17,009	16
17	32	Interest	WeightedCensus	470,290	14	181,530		35,124	13,558	17
18	34	Rent-Facility and Grounds	WeightedCensus	470,290	14	169,173		35,124	12,635	18
19	35	Rent-Equipment & Vehicles	WeightedCensus	470,290	14	30,003		35,124	2,241	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,257,795	$ 2,495,234		$ 317,996	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Cr Ctr Edwardsville # 0049031 Report Period Beginning: 07/01/2014 Ending: 6/30/2015

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: Claims Administration Services, LLC
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	19	Professional Services	WeightedCensus	470,290	14	3,980		35,124	$ 297	1
2	21	Clerical and General Office	WeightedCensus	470,290	14	229,689	226,926	35,124	17,154	2
3	24	Travel and Seminar	WeightedCensus	470,290	14	13,239		35,124	989	3
4	25	Other Admin. Staff Transport.	WeightedCensus	470,290	14	6,938		35,124	518	4
5	26	Insurance-Prop./Liab./Malprac.	WeightedCensus	470,290	14	2,943		35,124	220	5
6	27	Mgmt. Allocation of Benefits	WeightedCensus	470,290	14	24,684		35,124	1,844	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	TOTALS					$ 281,473	$ 226,926		$ 21,022	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Cr Ctr Edwardsville # 0049031 Report Period Beginning: 07/01/2014 Ending: 6/30/2015

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: Senior Living Services, Inc.
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	5	Utilities	WeightedCensus	470,290	14	4,237		35,124	$ 316	1
2	6	Maintenance	WeightedCensus/Direct Exp	470,290	14	513,005	471,253	35,124	37,535	2
3	7	Mgmt. Allocation of Benefits	WeightedCensus	470,290	14	60,169		35,124	4,494	3
4	19	Professional Services	WeightedCensus	470,290	14	123		35,124	9	4
5	21	Clerical and General Office	WeightedCensus	470,290	14	10,353		35,124	773	5
6	24	Travel and Seminar	WeightedCensus	470,290	14	46,417		35,124	3,467	6
7	25	Other Admin. Staff Transport.	WeightedCensus	470,290	14	41,082		35,124	3,068	7
8	26	Insurance-Prop./Liab./Malprac.	WeightedCensus	470,290	14	12,112		35,124	905	8
9	30	Depreciation	WeightedCensus	470,290	14	16,668		35,124	1,245	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	TOTALS					$ 704,166	$ 471,253		$ 51,812	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Cr Ctr Edwardsville # 0049031 Report Period Beginning: 07/01/2014 Ending: 6/30/2015

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 Holding Company
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	19	Professional Services	WeightedCensus	470,290	14	2,380,463		35,124	$ 177,787	1
2	20	Fees & Subscriptions	WeightedCensus	470,290	14	901		35,124	67	2
3	21	Clerical and General Office	WeightedCensus	470,290	14	12,160		35,124	908	3
4	24	Travel and Seminar	WeightedCensus	470,290	14	3,989		35,124	298	4
5	25	Other Admin. Staff Transport.	WeightedCensus	470,290	14	4,094		35,124	306	5
6	26	Insurance-Prop./Liab./Malprac.	WeightedCensus	470,290	14	9,723		35,124	726	6
7	32	Interest	WeightedCensus	470,290	14	255,901		35,124	19,112	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	TOTALS					$ 2,667,231	$		$ 199,204	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Cr Ctr Edwardsville # 0049031 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Berkadia		X	Mortgage	$86,175.55	7/1/04	$ 4,943,300	$ 11,298,967	8/1/39	0.0544	$ 309,054	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MidCap (Thru Allocation of		X	Revolving Line of Credit		8/1/09			12/31/15	5.0000	44,208	6
7	Bravo Holding Co.)											7
8												8
9	TOTAL Facility Related				$86,175.55		$ 4,943,300	$ 11,298,967			$ 353,262	9
	B. Non-Facility Related*											
10							Less: Interest Income Offset				(3,653)	10
11							Amortization Expense				5,204	11
12							Allocated from Mgmt Co's				32,670	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 34,221	14
15	TOTALS (line 9+line14)						$ 4,943,300	$ 11,298,967			$ 387,483	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 27,193 **Line #** 36

*** 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 Cr Ctr Edwardsville **#** 0049031 **Report Period Beginning:** 07/01/2014 **Ending:** 06/30/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 64,413	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.)	**See Below**	$ 62,739	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,674)	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 87,000	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.		$ 85,326	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:				
		2010	96,746	8
Taxes Paid-2013	62,739	2011	81,938	9
Taxes Paid-2014		2012	82,454	10
Total Taxes Paid	62,739	2013	83,653	11
		2014	83,548	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rosewood Cr Ctr Edwardsville COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0049031

CONTACT PERSON REGARDING THIS REPORT Mary Offner

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 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-1-15-22-00-000-002.004	S PT SE 15 & N PT NE 22	$ 83,547.88	$ 83,547.88
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 83,547.88	$ 83,547.88

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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 Cr Ctr Edwardsville # 0049031 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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 [X] (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? [X] (a) Own the Equipment [X] (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: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	496,222	2013	$ 401,071	1
2					2
3	TOTALS	496,222		$ 401,071	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Cr Ctr Edwardsville # 0049031 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	120		2013	1995	$ 2,452,281	$	40	$ 61,307	$ 61,307	$ 91,961	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements - Real Estate Entity										9
10											10
11	HVAC Improvements			2014	2,560		10	256	256	277	11
12	Replaced Hot Water Heater			2014	2,806		10	164	164	164	12
13	Sprinkler Repairs-Repaired Leaks, Replaced Pipes			2014	15,905		40	298	298	298	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 Cr Ctr Edwardsville # 0049031 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	Leasehold Improvements - Operating Entity		$	$		$	$	$	37
38									38
39	Wallpaper for 37 Guest Rooms	2008	6,993	666	7	666		6,993	39
40	Wall Coverings/Cove Base-Hall, 2 Dining Rooms	2013	4,380	626	7	626		1,147	40
41									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)		$ 2,484,925	$ 1,292		$ 63,317	$ 62,025	$ 100,840	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 Cr Ctr Edwardsville # 0049031 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 52,604	$ 10,520	$ 10,520	$	5	$ 21,782	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Allocated from Mgmt Co/Real Estate Entity	93,813		27,297	27,297	10	13,531	74
75	TOTALS	$ 146,417	$ 10,520	$ 37,817	$ 27,297		$ 35,313	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77	N/A									77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 3,032,413	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 11,812	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 101,134	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 89,322	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 136,153	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		$	$	$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93	N/A		93
94			94
95		$	95

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rosewood Cr Ctr Edwardsville # 0049031 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
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:				$			3
4	Additions							4
5								5
6	Allocated from Mgmt Co's				12,635			6
7	TOTAL				$ 12,635 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
   This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A .

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

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 21,287 Description: Offsite Storage - $2,617, Medical Equipment - $16,429, Home Office Allocation - $2,241
    (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	N/A		$	$	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 Cr Ctr Edwardsville # 0049031 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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

It is the policy of this facility to only hire certified nurses aides.

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 Cr Ctr Edwardsville # 0049031 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	7,500	$ 330,011	$	7,500	$ 330,011	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,884	97,952		1,884	97,952	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		10,153	385,813	1,872	10,153	387,685	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				188,419		188,419	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	19,537	$ 813,776	$ 190,291	19,537	$ 1,004,067	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 Cr Ctr Edwardsville # 0049031 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2015 (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	$ (59,299)	$ (58,092)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 301,000)	1,132,432	1,132,432	3
4	Supply Inventory (priced at Cost)	3,823	3,823	4
5	Short-Term Investments			5
6	Prepaid Insurance	25,858	29,334	6
7	Other Prepaid Expenses	3,838	3,838	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,106,652	$ 1,111,335	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		401,071	13
14	Buildings, at Historical Cost		2,468,186	14
15	Leasehold Improvements, at Historical Cost	11,373	16,739	15
16	Equipment, at Historical Cost	52,604	146,417	16
17	Accumulated Depreciation (book methods)	(29,922)	(136,153)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		115,827	21
22	Other Long-Term Assets (spe Loan Fees		240,642	22
23	Other(specify): Deposits	2,467	2,467	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 36,522	$ 3,255,196	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,143,174	$ 4,366,531	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 730,083	$ 761,608	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	140,219	140,219	30
31	Accrued Taxes Payable (excluding real estate taxes)	40,494	40,494	31
32	Accrued Real Estate Taxes(Sch.IX-B)		87,000	32
33	Accrued Interest Payable		8,435	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	5,016	5,016	35
	Other Current Liabilities(specify):			
36	Accrued Expenses	507,047	514,247	36
37	Accrued Rent	711,226		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,134,085	$ 1,557,019	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,298,967	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to Bravo Holding Company	1,698,631	1,698,631	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,698,631	$ 12,997,598	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,832,716	$ 14,554,617	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,689,542)	$ (10,188,086)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,143,174	$ 4,366,531	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Rosewood Cr Ctr Edwardsville # 0049031 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,914,710)	1
2	Restatements (describe):		2
3	**Prior year post closing adjustments**	41,992	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,872,718)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(816,824)	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)**	$ (816,824)	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)**	$ (2,689,542)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Cr Ctr Edwardsville # 0049031 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,598,544	1
2	Discounts and Allowances for all Levels	(1,600,400)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,998,144	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	439,405	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 439,405	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	1,200	13
14	Non-Patient Meals	2,167	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	90,634	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 94,001	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,621	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,621	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached Schedule	2,603	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,603	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,537,774	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,173,019	31
32	Health Care	3,788,034	32
33	General Administration	1,374,421	33
	B. Capital Expense		
34	Ownership	1,266,946	34
	C. Ancillary Expense		
35	Special Cost Centers	500,062	35
36	Provider Participation Fee	252,116	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,354,598	40
41	**Income before Income Taxes (line 30 minus line 40)****	(816,824)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (816,824)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,991,202	44
45	Private Pay - Net Inpatient Revenue	2,673,272	45
46	Medicare - Net Inpatient Revenue	1,750,606	46
47	Other-(specify) Insurance/Managed Care	583,064	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,998,144	49

* **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.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Cr Ctr Edwardsville

Period Beginning **07/01/2014**
Period End **06/30/2015**

Schedule 19A

Other Revenue:

Vending Income	**617**
Vendor Discount	**2,626**
Miscellaneous	**(640)**
Total Other Revenue	**2,603**

Facility Name & ID Number Rosewood Cr Ctr Edwardsville # 0049031 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,155	2,438	$ 76,624	$ 31.43	1
2	Assistant Director of Nursing	1,935	2,150	53,384	24.83	2
3	Registered Nurses	30,865	33,097	870,975	26.32	3
4	Licensed Practical Nurses	17,686	19,209	373,827	19.46	4
5	CNAs & Orderlies	93,507	98,031	989,713	10.10	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,101	2,253	30,083	13.35	8
9	Activity Director	2,154	2,467	23,043	9.34	9
10	Activity Assistants	2,671	2,842	24,383	8.58	10
11	Social Service Workers	4,241	4,636	55,404	11.95	11
12	Dietician					12
13	Food Service Supervisor	2,205	2,494	40,222	16.13	13
14	Head Cook	6,393	7,339	74,050	10.09	14
15	Cook Helpers/Assistants	11,975	12,631	106,990	8.47	15
16	Dishwashers					16
17	Maintenance Workers	2,352	2,448	47,746	19.50	17
18	Housekeepers	1,525	2,458	21,873	8.90	18
19	Laundry	549	730	6,239	8.55	19
20	Administrator	2,160	2,393	88,106	36.82	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,433	7,974	83,363	10.45	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	4,332	4,575	45,484	9.94	31
32	Other Health Care(specify)					32
33	Other(specify) See Sch 20A	12,191	13,067	280,846	21.49	33
34	TOTAL (lines 1 - 33)	208,430	223,232	$ 3,292,355 *	$ 14.75	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 7,315	L1, C3	35
36	Medical Director	Monthly	21,600	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,636	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,800	L11, C3	44
45	Social Service Consultant	Monthly	1,800	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 41,151		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	7	$ 301	L10, C3	50
51	Licensed Practical Nurses	114	3,663	L10, C3	51
52	Certified Nurse Assistants/Aides	54	1,083	L10, C3	52
53	TOTAL (lines 50 - 52)	175	$ 5,047		53

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Cr Ctr Edwardsville

Period Beginning 07/01/2014
Period End 06/30/2015

Schedule 20A

XVIII. Staffing and Salary Costs

		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Nurse		**2,319**	**2,539**	**60,687**	23.90
Case Manager		**2,293**	**2,414**	**61,693**	25.56
Rehabilitation Nurse		**1,038**	**1,038**	**28,686**	27.64
Ward Clerk		**2,138**	**2,207**	**40,491**	18.35
Marketing		**4,403**	**4,869**	**89,289**	18.34
	TOTAL	**12,191**	**13,067**	**280,846**	

Facility Name & ID Number Rosewood Cr Ctr Edwardsville # 0049031 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sara McMahon	Administrator	0	$ 88,106
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 88,106

B. Administrative - Other

Description	Amount
Mgmt Fees-Bravo Nursing Home Svc-See Pg 6, Elim on P 3, C 7	$ 138,000
Mgmt Fees-Midwest Admin Svc-See Pg 6, Elim on P 3, C 7	213,216
TOTAL (agree to Schedule V, line 17, col. 3)	$ 351,216
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Hochschild, Bloom & Company	Accountant/Consultant	$ 3,120
WestLaw	Computer Consulting	23,155
Odessa Healthcare	Consultant	75,303
Claims Administration Services, Inc.	Related Party Legal Fees	9,144
Daniel Maher	Legal Fees	2,523
Steven M. Hamburg PC	Legal Fees	14,632
MPRO	Legal Fees	735
Becker Paulson Hoerner & Thompso	Legal Fees	1,068
Various	Various below $200	176
Various	Court Costs	663
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 130,519

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 92,295
Unemployment Compensation Insurance	58,335
FICA Taxes	245,878
Employee Health Insurance	72,861
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	4,119
Employee Uniforms	804
Employee Physicals	3,059
Employee Drug Tests	84
Tuition Reimbursement	446
401K Expense	2,744
TOTAL (agree to Schedule V, line 22, col.8)	$ 480,625

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	896
Health Care Worker Background Check	
(Indicate # of checks performed 258)	3,358
Patient Background Checks	
Misc. Dues/Subscriptions/Fees	533
IHCA Dues	4,733
Mis. Licenses	698
Home Office Allocation	8,215
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,433

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Home Office Allocation	10,549
Seminar Expense	110
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,659

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Cr Ctr Edwardsville # 0049031 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3	N/A												
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 Cr Ctr Edwardsville # 0049031 **Report Period Beginning:** 07/01/2014 **Ending:** 06/30/2015

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. **4,733 IHCA**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(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? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **48,723** 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. $ **252,116**
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? **Yes**

(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. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,784**

(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? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.