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: 0049023

Facility Name: Rosewood Care Ctr Inverness

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

County: Cook

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: 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 Care Ctr Inverness # 0049023 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	142	Skilled (SNF)	142	51,830	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	142	TOTALS	142	51,830	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	16,326	13,838	8,902	39,066	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,326	13,838	8,902	39,066	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.37%

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 10/1/07

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 52 and days of care provided 8,096

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 Care Ctr Inverness # 0049023 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	248,061	27,642	13,599	289,302		289,302	5,194	294,496			1
2	Food Purchase		246,694		246,694		246,694	(6,728)	239,966			2
3	Housekeeping	31,200	15,422	203,570	250,192		250,192		250,192			3
4	Laundry	7,868	7,787	135,714	151,369		151,369		151,369			4
5	Heat and Other Utilities			203,137	203,137		203,137	521	203,658			5
6	Maintenance	27,934	4,750	234,084	266,768		266,768	(33,914)	232,854			6
7	Other (specify):* Allocated HO Benefits							5,546	5,546			7
8	TOTAL General Services	315,063	302,295	790,104	1,407,462		1,407,462	(29,381)	1,378,081			8
	B. Health Care and Programs											
9	Medical Director			16,800	16,800		16,800		16,800			9
10	Nursing and Medical Records	3,136,766	210,851	13,197	3,360,814		3,360,814	58,384	3,419,198			10
10a	Therapy		2,725	1,226,056	1,228,781		1,228,781		1,228,781			10a
11	Activities	69,775	3,676	2,448	75,899		75,899		75,899			11
12	Social Services	61,958		1,190	63,148		63,148		63,148			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Allocated HO Benefits							6,193	6,193			15
16	TOTAL Health Care and Programs	3,268,499	217,252	1,259,691	4,745,442		4,745,442	64,577	4,810,019			16
	C. General Administration											
17	Administrative	101,008		469,804	570,812		570,812	(402,494)	168,318			17
18	Directors Fees											18
19	Professional Services			171,488	171,488		171,488	163,888	335,376			19
20	Dues, Fees, Subscriptions & Promotions			17,809	17,809		17,809	5,476	23,285			20
21	Clerical & General Office Expenses	122,861	27,270	188,715	338,846		338,846	199,459	538,305			21
22	Employee Benefits & Payroll Taxes			501,164	501,164		501,164		501,164			22
23	Inservice Training & Education											23
24	Travel and Seminar			463	463		463	11,734	12,197			24
25	Other Admin. Staff Transportation			6,708	6,708		6,708	3,254	9,962			25
26	Insurance-Prop.Liab.Malpractice			78,080	78,080		78,080	17,846	95,926			26
27	Other (specify):* Allocated HO Benefits							29,880	29,880			27
28	TOTAL General Administration	223,869	27,270	1,434,231	1,685,370		1,685,370	29,043	1,714,413			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,807,431	546,817	3,484,026	7,838,274		7,838,274	64,239	7,902,513			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rosewood Care Ctr Inverness #0049023 Report Period Beginning: 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			17,815	17,815		17,815	237,787	255,602			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			111,038	111,038		111,038	312,540	423,578			32
33	Real Estate Taxes							475,392	475,392			33
34	Rent-Facility & Grounds			1,637,678	1,637,678		1,637,678	(1,623,625)	14,053			34
35	Rent-Equipment & Vehicles			15,052	15,052		15,052	2,492	17,544			35
36	Other (specify):* Mortgage Ins.							29,070	29,070			36
37	TOTAL Ownership			1,781,583	1,781,583		1,781,583	(566,344)	1,215,239			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		383,158		383,158		383,158		383,158			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			263,997	263,997		263,997		263,997			42
43	Other (specify):* See Att Sch 4A	110,206		410,232	520,438		520,438	(480,886)	39,552			43
44	TOTAL Special Cost Centers	110,206	383,158	674,229	1,167,593		1,167,593	(480,886)	686,707			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,917,637	929,975	5,939,838	10,787,450		10,787,450	(982,991)	9,804,459			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 Care Ctr Inverness

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	Supplies	Other	Total							
		1	2	3	4	5	6	7	8	9	10	
	Ancillary Expense											
	E. Special Cost Centers											
43	Other (specify):*				0		0		0			
	Laboratory/OP Expenses			24,350	24,350		24,350		24,350			
	Radiology Expenses			15,202	15,202		15,202		15,202			
	Non-Allowable Expenses	110,206		370,680	480,886		480,886	(480,886)	0			
					0		0		0			
					0		0		0			
	TOTAL Other Special Cost Centers	110,206	0	410,232	520,438	0	520,438	(480,886)	39,552			

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 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	(2,390)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,852)	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	(159,264)	30		9
10	Interest and Other Investment Income	(4,144)	32		10
11	Discounts, Allowances, Rebates & Refunds	(4,339)	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	(229)	20		17
18	Fines and Penalties				18
19	Entertainment	(83)	43		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,142)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(352,777)	43		24
25	Fund Raising, Advertising and Promotional	(10,024)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(926)	43		28
29	Other-Attach Schedule See Page 5A	(129,609)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (675,779)		$	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)	(307,212)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (307,212)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (982,991)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS **Page 5A**

Rosewood Care Ctr Inverness

ID# **0049023**

Report Period Beginning: **07/01/2014**

Ending: **06/30/2015**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate Marketing Salary	$ (110,206)	43	1
2	Eliminate Lobbying & PAC Dues	(3,120)	20	2
3	Miscellaneous Income Offset	360	21	3
4	Resident Reimbursements	(18)	43	4
5	Management Fee-Real Estate Entity	(7,200)	17	5
6	Mileage Reimbursement Related to Marketing	(5,539)	25	6
7	Disallow Late Fees on Real Estate Taxes	(3,886)	33	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**	(129,609)		49

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 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%	$ 934	$ 934	1
2	V	6	Maintenance		Bravo Nursing Home Services, Inc.	0.00%	33	33	2
3	V	7	Mgmt. Allocation of Benefits		Bravo Nursing Home Services, Inc.	0.00%	99	99	3
4	V	10	Nursing & Medical Records		Bravo Nursing Home Services, Inc.	0.00%	46,685	46,685	4
5	V	15	Mgmt. Allocation of Benefits		Bravo Nursing Home Services, Inc.	0.00%	4,959	4,959	5
6	V	17	Administrative	138,000	Bravo Nursing Home Services, Inc.	0.00%	16,967	(121,033)	6
7	V	19	Professional Services		Bravo Nursing Home Services, Inc.	0.00%	131	131	7
8	V	20	Dues, Fees, Subs & Promotions		Bravo Nursing Home Services, Inc.	0.00%	65	65	8
9	V	21	Clerical and General Office		Bravo Nursing Home Services, Inc.	0.00%	56,408	56,408	9
10	V	24	Travel and Seminar		Bravo Nursing Home Services, Inc.	0.00%	2,529	2,529	10
11	V	25	Other Admin. Staff Transport.		Bravo Nursing Home Services, Inc.	0.00%	2,234	2,234	11
12	V	26	Insurance-Prop./Liab./Malprac.		Bravo Nursing Home Services, Inc.	0.00%	244	244	12
13	V	27	Mgmt. Allocation of Benefits		Bravo Nursing Home Services, Inc.	0.00%	7,644	7,644	13
14	Total			$ 138,000			$ 138,932	$ * 932	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 Report Period Beginning: 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%	$ 4,260	$ 4,260	15
16	V	2	Food		Midwest Administrative Services, Inc.	0.00%	1	1	16
17	V	5	Utilities		Midwest Administrative Services, Inc.	0.00%	169	169	17
18	V	6	Maintenance		Midwest Administrative Services, Inc.	0.00%	1,292	1,292	18
19	V	7	Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	449	449	19
20	V	10	Nursing and Medical Records		Midwest Administrative Services, Inc.	0.00%	11,699	11,699	20
21	V	15	Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	1,234	1,234	21
22	V	17	Administrative	331,804	Midwest Administrative Services, Inc.	0.00%	50,343	(281,461)	22
23	V	19	Professional Services		Midwest Administrative Services, Inc.	0.00%	8,956	8,956	23
24	V	20	Dues, Fees, Subs & Promotions		Midwest Administrative Services, Inc.	0.00%	8,385	8,385	24
25	V	21	Clerical and General Office	72,310	Midwest Administrative Services, Inc.	0.00%	185,511	113,201	25
26	V	24	Travel and Seminar		Midwest Administrative Services, Inc.	0.00%	3,918	3,918	26
27	V	25	Other Admin. Staff Transport.		Midwest Administrative Services, Inc.	0.00%	2,230	2,230	27
28	V	26	Insurance-Prop./Liab./Malprac.		Midwest Administrative Services, Inc.	0.00%	4,508	4,508	28
29	V	27	Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	20,186	20,186	29
30	V	30	Depreciation		Midwest Administrative Services, Inc.	0.00%	18,918	18,918	30
31	V	32	Interest		Midwest Administrative Services, Inc.	0.00%	15,079	15,079	31
32	V	34	Rent-Facility and Grounds		Midwest Administrative Services, Inc.	0.00%	14,053	14,053	32
33	V	35	Rent-Equipment & Vehicles		Midwest Administrative Services, Inc.	0.00%	2,492	2,492	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 404,114			$ 353,683	$ * (50,431)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 Report Period Beginning: 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	$ 45,764	Claims Administration Services, LLC	0.00%	$ 331	$ (45,433)	15
16	V	21	Clerical and General Office		Claims Administration Services, LLC	0.00%	19,080	19,080	16
17	V	24	Travel and Seminar		Claims Administration Services, LLC	0.00%	1,100	1,100	17
18	V	25	Other Admin. Staff Transport.		Claims Administration Services, LLC	0.00%	576	576	18
19	V	26	Insurance-Prop./Liab./Malprac.		Claims Administration Services, LLC	0.00%	244	244	19
20	V	27	Mgmt. Allocation of Benefits		Claims Administration Services, LLC	0.00%	2,050	2,050	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			$ 45,764			$ 23,381	$ * (22,383)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 Report Period Beginning: 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%	$ 352	$ 352	15
16	V	6	Maintenance	77,215	Senior Living Services, Inc.	0.00%	41,976	(35,239)	16
17	V	7	Mgmt. Allocation of Benefits		Senior Living Services, Inc.	0.00%	4,998	4,998	17
18	V	19	Professional Services		Senior Living Services, Inc.	0.00%	10	10	18
19	V	21	Clerical and General Office		Senior Living Services, Inc.	0.00%	860	860	19
20	V	24	Travel and Seminar		Senior Living Services, Inc.	0.00%	3,856	3,856	20
21	V	25	Other Admin. Staff Transport.		Senior Living Services, Inc.	0.00%	3,413	3,413	21
22	V	26	Insurance-Prop./Liab./Malprac.		Senior Living Services, Inc.	0.00%	1,006	1,006	22
23	V	30	Depreciation		Senior Living Services, Inc.	0.00%	1,384	1,384	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			$ 77,215			$ 57,855	$ * (19,360)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 Report Period Beginning: 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%	$ 197,740	$ 197,740	15
16	V	20	Fees & Subscriptions		Bravo Holding Company	0.00%	75	75	16
17	V	21	Clerical and General Office		Bravo Holding Company	0.00%	1,010	1,010	17
18	V	24	Travel and Seminar		Bravo Holding Company	0.00%	331	331	18
19	V	25	Other Admin. Staff Transport.		Bravo Holding Company	0.00%	340	340	19
20	V	26	Insurance-Prop./Liab./Malprac.		Bravo Holding Company	0.00%	808	808	20
21	V	32	Interest	17,897	Bravo Holding Company	0.00%	21,257	3,360	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			$ 17,897			$ 221,561	$ * 203,664	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 Report Period Beginning: 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	$	Inverness Real Estate, LLC	0.00%	$ 7,200	$ 7,200	15
16	V	19	Professional Services		Inverness Real Estate, LLC	0.00%	7,626	7,626	16
17	V	20	Dues & Subscriptions		Inverness Real Estate, LLC	0.00%	300	300	17
18	V	21	Clerical and General Office		Inverness Real Estate, LLC	0.00%	8,540	8,540	18
19	V	26	Insurance-Prop./Liab./Malprac.		Inverness Real Estate, LLC	0.00%	11,036	11,036	19
20	V	30	Depreciation		Inverness Real Estate, LLC	0.00%	376,749	376,749	20
21	V	32	Interest	29	Inverness Real Estate, LLC	0.00%	298,274	298,245	21
22	V	33	Real Estate Taxes		Inverness Real Estate, LLC	0.00%	479,278	479,278	22
23	V	34	Rent-Facility and Grounds	1,637,678	Inverness Real Estate, LLC	0.00%		(1,637,678)	23
24	V	36	Mortgage Insurance		Inverness Real Estate, LLC	0.00%	29,070	29,070	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			$ 1,637,707			$ 1,218,073	$ * (419,634)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 Report Period Beginning: 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 Edwardsville, Inc.	Edwardsville, IL	Bravo Nursing Home			4
5			Bravo Care of Elgin, Inc.	Elgin, IL	Services, Inc.	St. Louis, MO	Management Co.	5
6			Bravo Care of Galeburg, Inc.	Galesburg, 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					Inverness Real			14
15					Estate, LLC	Inverness, 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 Care Ctr Inverness # 0049023 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	55,924	4.97	9.94	Salary	5,066	L17, C7	1
2	Mark Yampol	CEO	Administrative	0.00	1,375,398	See Above	See Above	Consulting	124,602	L19, C7	2
3	Hillel Yampol	Owner	Administrative	0.00	44,139	4.97	9.94	Salary	3,999	L17, C7	3
4	Christene Rene Yampol	Owner	Administrative	0.00	66,028	4.97	9.94	Salary	5,982	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	$ 139,649		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 Report Period Beginning: 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	39,066	$ 934	1
2	6	Maintenance	WeightedCensus	470,290	14	397		39,066	33	2
3	7	Mgmt. Allocation of Benefits	WeightedCensus	470,290	14	1,193		39,066	99	3
4	10	Nursing & Medical Records	WeightedCensus	470,290	14	562,016	562,016	39,066	46,685	4
5	15	Mgmt. Allocation of Benefits	WeightedCensus	470,290	14	59,699		39,066	4,959	5
6	17	Administrative	WeightedCensus	470,290	14	204,253	204,253	39,066	16,967	6
7	19	Professional Services	WeightedCensus	470,290	14	1,579		39,066	131	7
8	20	Dues, Fees, Subs & Promotions	WeightedCensus	470,290	14	786		39,066	65	8
9	21	Clerical and General Office	WeightedCensus	470,290	14	679,056	662,076	39,066	56,408	9
10	24	Travel and Seminar	WeightedCensus	470,290	14	30,438		39,066	2,529	10
11	25	Other Admin. Staff Transport.	WeightedCensus	470,290	14	26,889		39,066	2,234	11
12	26	Insurance-Prop./Liab./Malprac.	WeightedCensus	470,290	14	2,943		39,066	244	12
13	27	Mgmt. Allocation of Benefits	WeightedCensus	470,290	14	92,023		39,066	7,644	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		$ 138,932	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 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	39,066	$ 4,260	1
2	2	Food	WeightedCensus	470,290	14	13		39,066	1	2
3	5	Utilities	WeightedCensus	470,290	14	2,032		39,066	169	3
4	6	Maintenance	WeightedCensus	470,290	14	15,554		39,066	1,292	4
5	7	Mgmt. Allocation of Benefits	WeightedCensus	470,290	14	5,409		39,066	449	5
6	10	Nursing and Medical Records	WeightedCensus	470,290	14	140,839	140,839	39,066	11,699	6
7	15	Mgmt. Allocation of Benefits	WeightedCensus	470,290	14	14,860		39,066	1,234	7
8	17	Administrative	WeightedCensus	470,290	14	606,045	606,045	39,066	50,343	8
9	19	Professional Services	WeightedCensus	470,290	14	107,816		39,066	8,956	9
10	20	Dues, Fees, Subs & Promotions	WeightedCensus	470,290	14	100,942		39,066	8,385	10
11	21	Clerical and General Office	WeightedCensus	470,290	14	2,233,257	1,697,067	39,066	185,511	11
12	24	Travel and Seminar	WeightedCensus	470,290	14	47,164		39,066	3,918	12
13	25	Other Admin. Staff Transport.	WeightedCensus	470,290	14	26,845		39,066	2,230	13
14	26	Insurance-Prop./Liab./Malprac.	WeightedCensus	470,290	14	54,274		39,066	4,508	14
15	27	Mgmt. Allocation of Benefits	WeightedCensus	470,290	14	243,011		39,066	20,186	15
16	30	Depreciation	WeightedCensus	470,290	14	227,745		39,066	18,918	16
17	32	Interest	WeightedCensus	470,290	14	181,530		39,066	15,079	17
18	34	Rent-Facility and Grounds	WeightedCensus	470,290	14	169,173		39,066	14,053	18
19	35	Rent-Equipment & Vehicles	WeightedCensus	470,290	14	30,003		39,066	2,492	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,257,795	$ 2,495,234		$ 353,683	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 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		39,066	$ 331	1
2	21	Clerical and General Office	WeightedCensus	470,290	14	229,689	226,926	39,066	19,080	2
3	24	Travel and Seminar	WeightedCensus	470,290	14	13,239		39,066	1,100	3
4	25	Other Admin. Staff Transport.	WeightedCensus	470,290	14	6,938		39,066	576	4
5	26	Insurance-Prop./Liab./Malprac.	WeightedCensus	470,290	14	2,943		39,066	244	5
6	27	Mgmt. Allocation of Benefits	WeightedCensus	470,290	14	24,684		39,066	2,050	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		$ 23,381	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 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		39,066	$ 352	1
2	6	Maintenance	WeightedCensus/Direct Exp	470,290	14	513,005	471,253	39,066	41,976	2
3	7	Mgmt. Allocation of Benefits	WeightedCensus	470,290	14	60,169		39,066	4,998	3
4	19	Professional Services	WeightedCensus	470,290	14	123		39,066	10	4
5	21	Clerical and General Office	WeightedCensus	470,290	14	10,353		39,066	860	5
6	24	Travel and Seminar	WeightedCensus	470,290	14	46,417		39,066	3,856	6
7	25	Other Admin. Staff Transport.	WeightedCensus	470,290	14	41,082		39,066	3,413	7
8	26	Insurance-Prop./Liab./Malprac.	WeightedCensus	470,290	14	12,112		39,066	1,006	8
9	30	Depreciation	WeightedCensus	470,290	14	16,668		39,066	1,384	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		$ 57,855	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 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		39,066	$ 197,740	1
2	20	Fees & Subscriptions	WeightedCensus	470,290	14	901		39,066	75	2
3	21	Clerical and General Office	WeightedCensus	470,290	14	12,160		39,066	1,010	3
4	24	Travel and Seminar	WeightedCensus	470,290	14	3,989		39,066	331	4
5	25	Other Admin. Staff Transport.	WeightedCensus	470,290	14	4,094		39,066	340	5
6	26	Insurance-Prop./Liab./Malprac.	WeightedCensus	470,290	14	9,723		39,066	808	6
7	32	Interest	WeightedCensus	470,290	14	255,901		39,066	21,257	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	$		$ 221,561	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 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	$120,218.91	10/1/04	$ 14,387,100	$ 12,289,903	11/1/39	0.0474	$ 293,052	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	93,141	6
7	Bravo Holding Co.)											7
8												8
9	TOTAL Facility Related				$120,218.91		$ 14,387,100	$ 12,289,903			$ 386,193	9
	B. Non-Facility Related*											
10							Less: Interest Income Offset				(4,173)	10
11							Amortization Expense				5,222	11
12							Allocated from Mgmt Co's				36,336	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 37,385	14
15	TOTALS (line 9+line14)						$ 14,387,100	$ 12,289,903			$ 423,578	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 29,070 **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 Care Ctr Inverness # 0049023 **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.**	$ 479,278	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**	$ 467,376	2
3. Under or (over) accrual (line 2 minus line 1).		$ (11,902)	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 487,294	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.		$ 475,392	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:				
		2010	666,213	8
Taxes Paid-2013	208,942	2011	530,616	9
Taxes Paid-2014	258,434	2012	546,928	10
Total Taxes Paid	467,376	2013	469,881	11
		2014	756,450	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 Care Ctr Inverness COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049023

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.	02-28-301-017-0000	1800 Colonial Pky, Inverness 5-97	$ 755,629.57	$ 755,629.57
2.	02-28-301-039-0000	1800 Colonial Pky, Inverness 1-00	$ 820.86	$ 820.86
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 756,450.43	$ 756,450.43

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 Care Ctr Inverness # 0049023 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [ ] (a) Own the Facility [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		2000	$ 1,382,237	1
2					2
3	TOTALS			$ 1,382,237	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 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	142		2013	2000	$ 7,846,364	$	40	$ 196,159	$ 196,159	$ 294,239	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements - Real Estate Entity										9
10											10
11	HVAC Improvements			2014	3,738		10	374	374	499	11
12	Sprinkler			2014	14,324		40	358	358	506	12
13	Replace Irrigation Zone Controller, Repaired Leaks/Heads			2014	2,920		25	117	117	117	13
14	Fire Hydrant Repairs-North Side of Building			2014	12,401		25	372	372	372	14
15	Replaced Valves on Hot Water Storage Tanks			2014	3,937		10	361	361	361	15
16	Sprinkler Repair			2015	4,177		40	52	52	52	16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 Report Period Beginning: 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	Fire Hydrants	2014	10,513	1,502	7	1,502		1,627	39
40									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)		$ 7,898,374	$ 1,502		$ 199,295	$ 197,793	$ 297,773	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 Report Period Beginning: 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	$ 81,564	$ 16,313	$ 16,313	$	5	$ 36,222	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Allocated from Mgmt Co/Real Estate Entity	196,911		39,994	39,994	10	29,538	74
75	TOTALS	$ 278,475	$ 16,313	$ 56,307	$ 39,994		$ 65,760	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)	$ 9,559,086	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 17,815	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 255,602	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 237,787	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 363,533	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 Care Ctr Inverness # 0049023 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? ☐ YES ☐ NO
   If NO, see instructions.

		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				14,053			6
7	TOTAL				$ 14,053 **			7

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	$

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 *

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: $ 17,544 Description: Medical Equipment - $15,052, Home Office Allocation - $2,492
    (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 Care Ctr Inverness # 0049023 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 Care Ctr Inverness # 0049023 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	$	13,653	$ 505,143	$	13,653	$ 505,143	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,457	130,228		2,457	130,228	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		13,425	590,685	2,725	13,425	593,410	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				383,158		383,158	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			$	29,535	$ 1,226,056	$ 385,883	29,535	$ 1,611,939	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

STATE OF ILLINOIS

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 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	$ (23,332)	$ (18,609)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 741,000)	1,850,059	1,850,059	3
4	Supply Inventory (priced at Cost)	4,565	4,565	4
5	Short-Term Investments			5
6	Prepaid Insurance	30,598	35,222	6
7	Other Prepaid Expenses	4,021	4,021	7
8	Accounts Receivable (owners or related parties)	515,102	515,102	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,381,013	$ 2,390,360	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,382,237	13
14	Buildings, at Historical Cost		7,850,540	14
15	Leasehold Improvements, at Historical Cost	10,513	47,834	15
16	Equipment, at Historical Cost	81,564	278,475	16
17	Accumulated Depreciation (book methods)	(37,849)	(363,533)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		124,722	21
22	Other Long-Term Assets (spe Loan Fees		214,203	22
23	Other(specify): Deposits	2,000	2,000	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 56,228	$ 9,536,478	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,437,241	$ 11,926,838	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,076,709	$ 1,088,376	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	240,704	240,704	30
31	Accrued Taxes Payable (excluding real estate taxes)	49,802	49,802	31
32	Accrued Real Estate Taxes(Sch.IX-B)		487,294	32
33	Accrued Interest Payable		8,540	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	14,377	14,377	35
	Other Current Liabilities(specify):			
36	Accrued Expenses	735,687	746,887	36
37	Accrued Rent	1,892,889	(3,209)	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,010,168	$ 2,632,771	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		12,289,903	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 12,289,903	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,010,168	$ 14,922,674	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,572,927)	$ (2,995,836)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,437,241	$ 11,926,838	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 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**	$ (1,683,808)	1
2	Restatements (describe):		2
3	**Prior period post closing adjustments**	(13,162)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,696,970)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	124,043	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)**	$ 124,043	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,572,927)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 Report Period Beginning: 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	$ 12,987,486	1
2	Discounts and Allowances for all Levels	(2,733,361)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,254,125	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	624,772	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 624,772	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,100	13
14	Non-Patient Meals	2,164	14
15	Telephone, Television and Radio	195	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	300	20
21	Other Medical Services	19,488	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 24,247	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,144	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,144	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached Schedule 19A	4,205	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,205	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,911,493	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,407,462	31
32	Health Care	4,745,442	32
33	General Administration	1,685,370	33
	B. Capital Expense		
34	Ownership	1,781,583	34
	C. Ancillary Expense		
35	Special Cost Centers	903,596	35
36	Provider Participation Fee	263,997	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,787,450	40
41	**Income before Income Taxes (line 30 minus line 40)****	124,043	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 124,043	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,722,891	44
45	Private Pay - Net Inpatient Revenue	3,220,279	45
46	Medicare - Net Inpatient Revenue	4,016,449	46
47	Other-(specify) Insurance/Managed Care	294,506	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,254,125	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 Care Ctr Inverness

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

Schedule 19A

Other Revenue:

Vending Income	**226**
Vendor Discount	**4,339**
Miscellaneous	**(360)**
Total Other Revenue	**4,205**

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 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	2,200	2,369	$ 111,888	$ 47.23	1
2	Assistant Director of Nursing	751	964	38,980	40.44	2
3	Registered Nurses	41,836	44,862	1,203,576	26.83	3
4	Licensed Practical Nurses	16,866	18,135	370,180	20.41	4
5	CNAs & Orderlies	87,490	93,105	1,031,482	11.08	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,120	2,120	32,783	15.46	8
9	Activity Director	2,441	2,615	44,207	16.91	9
10	Activity Assistants	2,813	2,935	25,568	8.71	10
11	Social Service Workers	4,264	4,504	61,958	13.76	11
12	Dietician					12
13	Food Service Supervisor	2,361	2,619	44,887	17.14	13
14	Head Cook	7,130	7,806	76,738	9.83	14
15	Cook Helpers/Assistants	14,344	15,181	126,436	8.33	15
16	Dishwashers					16
17	Maintenance Workers	2,107	2,323	27,934	12.02	17
18	Housekeepers	921	2,490	31,200	12.53	18
19	Laundry	488	855	7,868	9.20	19
20	Administrator	2,160	2,288	101,008	44.15	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,070	9,675	122,861	12.70	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	3,410	3,692	45,915	12.44	31
32	Other Health Care(specify)					32
33	Other(specify) See Sch 20A	14,536	15,935	412,168	25.87	33
34	TOTAL (lines 1 - 33)	217,308	234,473	$ 3,917,637 *	$ 16.71	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	$ 13,599	L1, C3	35
36	Medical Director	Monthly	16,800	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,198	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	2,448	L11, C3	44
45	Social Service Consultant	Monthly	1,190	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 42,235		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Care Ctr Inverness

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	**2,913**	**3,069**	**77,971**	25.41
Case Manager	**4,516**	**4,927**	**154,416**	31.34
Rehabilitation Nurse	**2,982**	**3,370**	**69,575**	20.65
Marketing	**4,125**	**4,569**	**110,206**	24.12
TOTAL	**14,536**	**15,935**	**412,168**	

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Patrick Dipaolo	Administrator	0	$ 101,008
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 101,008

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	331,804
TOTAL (agree to Schedule V, line 17, col. 3)	$ 469,804
(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	2,768
Odessa Healthcare	Consultant	89,109
Claims Administration Services, Inc.	Related Party Legal Fees	45,764
Daniel Maher	Legal Fees	6,054
Kelly, Olson, Michod, DeHaan, Richt	Legal Fees	5,767
Kanu Panchal, MD, F.A.C.S	Court Reporter	1,520
Eldercare Decisions, Inc.	Legal Fees	2,637
McCorkle Court Reporters	Court Reporter	2,650
Mulherin, Rehfeldt & Varchetto, P.C	Legal Fees	11,807
Various	Various below $200	292
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 171,488

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 110,273
Unemployment Compensation Insurance	28,927
FICA Taxes	295,613
Employee Health Insurance	53,199
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	4,217
Employee Uniforms	1,020
Employee Physicals	2,258
Employee Drug Tests	788
401K Expense	4,869
TOTAL (agree to Schedule V, line 22, col.8)	$ 501,164

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	$ 3,980
Advertising: Employee Recruitment	896
Health Care Worker Background Check	
(Indicate # of checks performed 275)	3,580
Patient Background Checks	
Misc. Dues/Subscriptions/Fees	612
IHCA Dues	5,008
Misc. Licenses	613
Home Office Allocation	8,825
Less: Public Relations Expense	(229)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,285

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	77
Home Office Allocation	11,734
Seminar Expense	615
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,426

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr Inverness # 0049023 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 Care Ctr Inverness # 0049023 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. **5,008 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. $ **77,808** 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. $ **263,997**
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. $ **2,390**

(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.