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: 0049320

Facility Name: Rosewood Care Ctr St Charles

Address: 850 Dunham Road (Number) St Charles (City) 60174 (Zip Code)

County: Kane

Telephone Number: (630)443-6146 **Fax #** (630)443-4461

HFS ID Number:

Date of Initial License for Current Owners: 12/1/07

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 St Charles # 0049320 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	109	Skilled (SNF)	109	39,785	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	109	TOTALS	109	39,785	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	17,704	7,799	7,537	33,040	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,704	7,799	7,537	33,040	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.05%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X] 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 12/1/07

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/1/07 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 49 and days of care provided 5,435

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 St Charles # 0049320 **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				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	259,703	30,237	11,186	301,126		301,126	4,393	305,519			1
2	Food Purchase		242,165		242,165		242,165	(5,386)	236,779			2
3	Housekeeping	20,990	9,918	157,635	188,543		188,543		188,543			3
4	Laundry	3,978	10,445	104,527	118,950		118,950		118,950			4
5	Heat and Other Utilities			181,895	181,895		181,895	441	182,336			5
6	Maintenance	36,897	10,292	193,544	240,733		240,733	(42,990)	197,743			6
7	Other (specify):* Allocated HO Benefits							4,691	4,691			7
8	**TOTAL General Services**	321,568	303,057	648,787	1,273,412		1,273,412	(38,851)	1,234,561			8
	B. Health Care and Programs											
9	Medical Director			3,281	3,281		3,281		3,281			9
10	Nursing and Medical Records	2,621,680	211,958	17,165	2,850,803		2,850,803	49,379	2,900,182			10
10a	Therapy		1,094	755,658	756,752		756,752		756,752			10a
11	Activities	72,933	5,496	1,012	79,441		79,441		79,441			11
12	Social Services	55,145		1,600	56,745		56,745		56,745			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Allocated HO Benefits							5,238	5,238			15
16	**TOTAL Health Care and Programs**	2,749,758	218,548	778,716	3,747,022		3,747,022	54,617	3,801,639			16
	C. General Administration											
17	Administrative	108,369		369,839	478,208		478,208	(312,912)	165,296			17
18	Directors Fees											18
19	Professional Services			89,182	89,182		89,182	175,012	264,194			19
20	Dues, Fees, Subscriptions & Promotions			13,510	13,510		13,510	6,312	19,822			20
21	Clerical & General Office Expenses	110,962	24,357	128,965	264,284		264,284	181,449	445,733			21
22	Employee Benefits & Payroll Taxes			460,622	460,622		460,622		460,622			22
23	Inservice Training & Education			270	270		270		270			23
24	Travel and Seminar							9,922	9,922			24
25	Other Admin. Staff Transportation			8,578	8,578		8,578	233	8,811			25
26	Insurance-Prop.Liab.Malpractice			42,981	42,981		42,981	13,868	56,849			26
27	Other (specify):* Allocated HO Benefits							25,272	25,272			27
28	**TOTAL General Administration**	219,331	24,357	1,113,947	1,357,635		1,357,635	99,156	1,456,791			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,290,657	545,962	2,541,450	6,378,069		6,378,069	114,922	6,492,991			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 St Charles #0049320 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			15,979	15,979		15,979	142,916	158,895			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			196,070	196,070		196,070	130,787	326,857			32
33	Real Estate Taxes							144,017	144,017			33
34	Rent-Facility & Grounds			1,083,040	1,083,040		1,083,040	(1,071,155)	11,885			34
35	Rent-Equipment & Vehicles			35,645	35,645		35,645	2,108	37,753			35
36	Other (specify):* MIP							26,528	26,528			36
37	TOTAL Ownership			1,330,734	1,330,734		1,330,734	(624,799)	705,935			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		265,075		265,075		265,075		265,075			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			225,577	225,577		225,577		225,577			42
43	Other (specify):* See Att Sch 4A	95,783		349,812	445,595		445,595	(415,514)	30,081			43
44	TOTAL Special Cost Centers	95,783	265,075	575,389	936,247		936,247	(415,514)	520,733			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,386,440	811,037	4,447,573	8,645,050		8,645,050	(925,391)	7,719,659			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 St Charles

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 Expense			17,751	17,751		17,751		17,751			
	Radiology Expenses			12,330	12,330		12,330		12,330			
	Non-Allowable Expenses	95,783		319,731	415,514		415,514	(415,514)	0			
					0		0		0			
					0		0		0			
	TOTAL Other Special Cost Centers	95,783	0	349,812	445,595	0	445,595	(415,514)	30,081			

Facility Name & ID Number Rosewood Care Ctr St Charles # 0049320 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	(1,566)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,721)	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	(117,017)	30		9
10	Interest and Other Investment Income	(2,717)	32		10
11	Discounts, Allowances, Rebates & Refunds	(3,821)	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	(673)	43		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,063)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(305,814)	43		24
25	Fund Raising, Advertising and Promotional	(3,903)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(620)	43		28
29	Other-Attach Schedule See Page 5A	(107,644)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (553,559)		$	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)	(371,832)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (371,832)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (925,391)		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 St Charles

ID# **0049320**

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

Ending: **06/30/2015**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate Marketing Salary	$ (95,783)	43	1
2	Eliminate Lobbying & PAC Dues	(1,198)	20	2
3	Miscellaneous Income Offset	3,741	21	3
4	Management Fee-Real Estate Entity	(7,200)	17	4
5	Mileage Reimbursement Related to Marketing	(7,204)	25	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(107,644)		49

Facility Name & ID Number Rosewood Care Ctr St Charles # 0049320 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%	$ 3,603	$ 3,603	15
16	V	2	Food		Midwest Administrative Services, Inc.	0.00%	1	1	16
17	V	5	Utilities		Midwest Administrative Services, Inc.	0.00%	143	143	17
18	V	6	Maintenance		Midwest Administrative Services, Inc.	0.00%	1,093	1,093	18
19	V	7	Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	380	380	19
20	V	10	Nursing and Medical Records		Midwest Administrative Services, Inc.	0.00%	9,895	9,895	20
21	V	15	Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	1,044	1,044	21
22	V	17	Administrative	231,839	Midwest Administrative Services, Inc.	0.00%	42,577	(189,262)	22
23	V	19	Professional Services		Midwest Administrative Services, Inc.	0.00%	7,575	7,575	23
24	V	20	Dues, Fees, Subs & Promotions		Midwest Administrative Services, Inc.	0.00%	7,092	7,092	24
25	V	21	Clerical and General Office	55,505	Midwest Administrative Services, Inc.	0.00%	156,899	101,394	25
26	V	24	Travel and Seminar		Midwest Administrative Services, Inc.	0.00%	3,313	3,313	26
27	V	25	Other Admin. Staff Transport.		Midwest Administrative Services, Inc.	0.00%	1,886	1,886	27
28	V	26	Insurance-Prop./Liab./Malprac.		Midwest Administrative Services, Inc.	0.00%	3,813	3,813	28
29	V	27	Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	17,073	17,073	29
30	V	30	Depreciation		Midwest Administrative Services, Inc.	0.00%	16,000	16,000	30
31	V	32	Interest		Midwest Administrative Services, Inc.	0.00%	12,753	12,753	31
32	V	34	Rent-Facility and Grounds		Midwest Administrative Services, Inc.	0.00%	11,885	11,885	32
33	V	35	Rent-Equipment & Vehicles		Midwest Administrative Services, Inc.	0.00%	2,108	2,108	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 287,344			$ 299,133	$ * 11,789	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 St Charles # 0049320 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	$ 5,264	Claims Administration Services, LLC	0.00%	$ 280	$ (4,984)	15
16	V	21	Clerical and General Office		Claims Administration Services, LLC	0.00%	16,137	16,137	16
17	V	24	Travel and Seminar		Claims Administration Services, LLC	0.00%	930	930	17
18	V	25	Other Admin. Staff Transport.		Claims Administration Services, LLC	0.00%	488	488	18
19	V	26	Insurance-Prop./Liab./Malprac.		Claims Administration Services, LLC	0.00%	207	207	19
20	V	27	Mgmt. Allocation of Benefits		Claims Administration Services, LLC	0.00%	1,734	1,734	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			$ 5,264			$ 19,776	$ * 14,512	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 St Charles # 0049320 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%	$ 298	$ 298	15
16	V	6	Maintenance	79,653	Senior Living Services, Inc.	0.00%	35,542	(44,111)	16
17	V	7	Mgmt. Allocation of Benefits		Senior Living Services, Inc.	0.00%	4,227	4,227	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%	727	727	19
20	V	24	Travel and Seminar		Senior Living Services, Inc.	0.00%	3,261	3,261	20
21	V	25	Other Admin. Staff Transport.		Senior Living Services, Inc.	0.00%	2,886	2,886	21
22	V	26	Insurance-Prop./Liab./Malprac.		Senior Living Services, Inc.	0.00%	851	851	22
23	V	30	Depreciation		Senior Living Services, Inc.	0.00%	1,171	1,171	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			$ 79,653			$ 48,972	$ * (30,681)	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 St Charles # 0049320 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%	$ 167,238	$ 167,238	15
16	V	20	Fees & Subscriptions		Bravo Holding Company	0.00%	63	63	16
17	V	21	Clerical and General Office		Bravo Holding Company	0.00%	854	854	17
18	V	24	Travel and Seminar		Bravo Holding Company	0.00%	280	280	18
19	V	25	Other Admin. Staff Transport.		Bravo Holding Company	0.00%	288	288	19
20	V	26	Insurance-Prop./Liab./Malprac.		Bravo Holding Company	0.00%	683	683	20
21	V	32	Interest	166,533	Bravo Holding Company	0.00%	17,978	(148,555)	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			$ 166,533			$ 187,384	$ * 20,851	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 St Charles # 0049320 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	$	St. Charles Real Estate, LLC	0.00%	$ 7,200	$ 7,200	15
16	V	19	Professional Services		St. Charles Real Estate, LLC	0.00%	6,126	6,126	16
17	V	20	Dues & Subscriptions		St. Charles Real Estate, LLC	0.00%	300	300	17
18	V	21	Clerical and General Office		St. Charles Real Estate, LLC	0.00%	10,889	10,889	18
19	V	26	Insurance-Prop./Liab./Malprac.		St. Charles Real Estate, LLC	0.00%	8,107	8,107	19
20	V	30	Depreciation		St. Charles Real Estate, LLC	0.00%	242,762	242,762	20
21	V	32	Interest	28	St. Charles Real Estate, LLC	0.00%	269,334	269,306	21
22	V	33	Real Estate Taxes		St. Charles Real Estate, LLC	0.00%	144,017	144,017	22
23	V	34	Rent-Facility and Grounds	1,083,040	St. Charles Real Estate, LLC	0.00%		(1,083,040)	23
24	V	36	Mortgage Insurance		St. Charles Real Estate, LLC	0.00%	26,528	26,528	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			$ 1,083,068			$ 715,263	$ * (367,805)	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 St Charles # 0049320 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 East 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 Inverness, Inc.	Inverness, IL	Company, Inc.	St. Louis, MO	Holding Co.	7
8			Bravo Care of Joliet, Inc.	Joliet, IL	Senior Living		Building Services	8
9			Bravo Care of Moline, Inc.	Moline, IL	Services, Inc.	St. Louis, MO	Company	9
10			Bravo Care of Northbrook, Inc.	Northbrook, IL	Bravo Team		Human Resources	10
11			Bravo Care of Peoria, Inc.	Peoria, IL	Health, Inc.	St. Louis, MO	Company	11
12			Bravo Care of Rockford, Inc.	Rockford, IL	Claims Administration		Legal Services	12
13			Bravo Care of St. Louis, Inc.	St. Louis, MO	Services, LLC	St. Louis, MO		13
14					St. Charles Real			14
15					Estate, LLC	St. Charles, 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 St Charles # 0049320 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	56,705	4.97	9.94	Salary	4,285	L17, C7	1
2	Mark Yampol	CEO	Administrative	0.00	1,394,617	See Above	See Above	Consulting	105,383	L19, C7	2
3	Hillel Yampol	Owner	Administrative	0.00	44,756	4.97	9.94	Salary	3,382	L17, C7	3
4	Christene Rene Yampol	Owner	Administrative	0.00	66,951	4.97	9.94	Salary	5,059	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	$ 118,109		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 St Charles # 0049320 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	33,040	$ 790	1
2	6	Maintenance	WeightedCensus	470,290	14	397		33,040	28	2
3	7	Mgmt. Allocation of Benefits	WeightedCensus	470,290	14	1,193		33,040	84	3
4	10	Nursing & Medical Records	WeightedCensus	470,290	14	562,016	562,016	33,040	39,484	4
5	15	Mgmt. Allocation of Benefits	WeightedCensus	470,290	14	59,699		33,040	4,194	5
6	17	Administrative	WeightedCensus	470,290	14	204,253	204,253	33,040	14,350	6
7	19	Professional Services	WeightedCensus	470,290	14	1,579		33,040	111	7
8	20	Dues, Fees, Subs & Promotions	WeightedCensus	470,290	14	786		33,040	55	8
9	21	Clerical and General Office	WeightedCensus	470,290	14	679,056	662,076	33,040	47,707	9
10	24	Travel and Seminar	WeightedCensus	470,290	14	30,438		33,040	2,138	10
11	25	Other Admin. Staff Transport.	WeightedCensus	470,290	14	26,889		33,040	1,889	11
12	26	Insurance-Prop./Liab./Malprac.	WeightedCensus	470,290	14	2,943		33,040	207	12
13	27	Mgmt. Allocation of Benefits	WeightedCensus	470,290	14	92,023		33,040	6,465	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		$ 117,502	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr St Charles # 0049320 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	33,040	$ 3,603	1
2	2	Food	WeightedCensus	470,290	14	13		33,040	1	2
3	5	Utilities	WeightedCensus	470,290	14	2,032		33,040	143	3
4	6	Maintenance	WeightedCensus	470,290	14	15,554		33,040	1,093	4
5	7	Mgmt. Allocation of Benefits	WeightedCensus	470,290	14	5,409		33,040	380	5
6	10	Nursing and Medical Records	WeightedCensus	470,290	14	140,839	140,839	33,040	9,895	6
7	15	Mgmt. Allocation of Benefits	WeightedCensus	470,290	14	14,860		33,040	1,044	7
8	17	Administrative	WeightedCensus	470,290	14	606,045	606,045	33,040	42,577	8
9	19	Professional Services	WeightedCensus	470,290	14	107,816		33,040	7,575	9
10	20	Dues, Fees, Subs & Promotions	WeightedCensus	470,290	14	100,942		33,040	7,092	10
11	21	Clerical and General Office	WeightedCensus	470,290	14	2,233,257	1,697,067	33,040	156,899	11
12	24	Travel and Seminar	WeightedCensus	470,290	14	47,164		33,040	3,313	12
13	25	Other Admin. Staff Transport.	WeightedCensus	470,290	14	26,845		33,040	1,886	13
14	26	Insurance-Prop./Liab./Malprac.	WeightedCensus	470,290	14	54,274		33,040	3,813	14
15	27	Mgmt. Allocation of Benefits	WeightedCensus	470,290	14	243,011		33,040	17,073	15
16	30	Depreciation	WeightedCensus	470,290	14	227,745		33,040	16,000	16
17	32	Interest	WeightedCensus	470,290	14	181,530		33,040	12,753	17
18	34	Rent-Facility and Grounds	WeightedCensus	470,290	14	169,173		33,040	11,885	18
19	35	Rent-Equipment & Vehicles	WeightedCensus	470,290	14	30,003		33,040	2,108	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,257,795	$ 2,495,234		$ 299,133	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr St Charles # 0049320 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		33,040	$ 280	1
2	21	Clerical and General Office	WeightedCensus	470,290	14	229,689	226,926	33,040	16,137	2
3	24	Travel and Seminar	WeightedCensus	470,290	14	13,239		33,040	930	3
4	25	Other Admin. Staff Transport.	WeightedCensus	470,290	14	6,938		33,040	488	4
5	26	Insurance-Prop./Liab./Malprac.	WeightedCensus	470,290	14	2,943		33,040	207	5
6	27	Mgmt. Allocation of Benefits	WeightedCensus	470,290	14	24,684		33,040	1,734	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		$ 19,776	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr St Charles # 0049320 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		33,040	$ 298	1
2	6	Maintenance	WeightedCensus/Direct Exp	470,290	14	513,005	471,253	33,040	35,542	2
3	7	Mgmt. Allocation of Benefits	WeightedCensus	470,290	14	60,169		33,040	4,227	3
4	19	Professional Services	WeightedCensus	470,290	14	123		33,040	9	4
5	21	Clerical and General Office	WeightedCensus	470,290	14	10,353		33,040	727	5
6	24	Travel and Seminar	WeightedCensus	470,290	14	46,417		33,040	3,261	6
7	25	Other Admin. Staff Transport.	WeightedCensus	470,290	14	41,082		33,040	2,886	7
8	26	Insurance-Prop./Liab./Malprac.	WeightedCensus	470,290	14	12,112		33,040	851	8
9	30	Depreciation	WeightedCensus	470,290	14	16,668		33,040	1,171	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		$ 48,972	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr St Charles # 0049320 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		33,040	$ 167,238	1
2	20	Fees & Subscriptions	WeightedCensus	470,290	14	901		33,040	63	2
3	21	Clerical and General Office	WeightedCensus	470,290	14	12,160		33,040	854	3
4	24	Travel and Seminar	WeightedCensus	470,290	14	3,989		33,040	280	4
5	25	Other Admin. Staff Transport.	WeightedCensus	470,290	14	4,094		33,040	288	5
6	26	Insurance-Prop./Liab./Malprac.	WeightedCensus	470,290	14	9,723		33,040	683	6
7	32	Interest	WeightedCensus	470,290	14	255,901		33,040	17,978	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	$		$ 187,384	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr St Charles # 0049320 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	$82,450.45	11/1/04	$ 9,101,649	$ 11,200,591	12/1/39	0.0469	$ 264,263	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	29,537	6
7	Bravo Holding Co.)											7
8												8
9	TOTAL Facility Related				$82,450.45		$ 9,101,649	$ 11,200,591			$ 293,800	9
	B. Non-Facility Related*											
10							Less: Interest Income Offset				(2,745)	10
11							Amortization Expense				5,071	11
12							Allocated from Mgmt Co's				30,731	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 33,057	14
15	TOTALS (line 9+line14)						$ 9,101,649	$ 11,200,591			$ 326,857	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 26,528 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 St Charles # 0049320 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.**	$ 144,017	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	$ 144,699	2
3. Under or (over) accrual (line 2 minus line 1).		$ 682	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 143,335	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** $ 12,330 **For** 13 **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.		$ 144,017	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
Taxes Paid-2013	**70,596**	**2010**	159,502	**8**
Taxes Paid-2014	**74,103**	**2011**	181,171	**9**
Total Taxes Paid	**144,699**	**2012**	110,066	**10**
		2013	141,193	**11**
		2014	148,206	**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 St Charles COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0049320

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.	09-26-226-008	850 Dunham Road	$ 148,205.52	$ 148,205.52
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 148,205.52	$ 148,205.52

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 St Charles # 0049320 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,252 B. General Construction Type: Exterior Brick Veneer Frame Steel 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	8.35 Acres	2013	$ 1,577,420	1
2					2
3	TOTALS	#VALUE!		$ 1,577,420	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr St Charles # 0049320 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	109		2013	1999	$ 4,302,741	$	40	$ 107,569	$ 107,569	$ 161,353	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements - Real Estate Entity										9
10											10
11	Window Sills			2014	8,338		40	208	208	312	11
12	Doors			2014	4,190		40	105	105	122	12
13	Cooling Tower			2014	3,717		10	372	372	434	13
14	Concrete Sidewalk			2014	6,000		25	240	240	280	14
15	Seal Coating			2014	6,303		25	189	189	229	15
16	Replace Shower Wall			2015	5,079		40	42	42	82	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 St Charles # 0049320 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 Facility		$	$		$	$	$	37
38									38
39	Carpet Installation	2009	13,142	1,877	7	1,877		11,733	39
40	Acrovyn for Walls, Doors	2009	4,206	601	7	601		3,455	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)		$ 4,353,716	$ 2,478		$ 111,203	$ 108,725	$ 178,000	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 St Charles # 0049320 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	$ 60,770	$ 12,154	$ 12,154	$	5	$ 27,801	71
72	Current Year Purchases	6,730	1,346	1,346			1,346	72
73	Fully Depreciated Assets							73
74	Allocated from Mgmt Co/Real Estate Entity	173,186		34,192	34,192	10	25,482	74
75	TOTALS	$ 240,686	$ 13,500	$ 47,692	$ 34,192		$ 54,629	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)	$ 6,171,822	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 15,978	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 158,895	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 142,917	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 232,629	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 St Charles # 0049320 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				11,885			6
7	TOTAL				$ 11,885 **			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: $ 37,753 Description: Offsite Storage - $5,430, Medical Equipment - $30,215, Home Office Allocation - $2,108
    (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 St Charles # 0049320 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 St Charles # 0049320 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	$	7,229	$ 318,055	$	7,229	$ 318,055	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,612	82,192		1,612	82,192	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		7,726	355,411	1,094	7,726	356,505	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				265,075		265,075	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			$	16,567	$ 755,658	$ 266,169	16,567	$ 1,021,827	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 St Charles # 0049320 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	$ (14,914)	$ 3,192	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 547,000)	1,631,527	1,631,527	3
4	Supply Inventory (priced at Cost)	4,522	4,522	4
5	Short-Term Investments			5
6	Prepaid Insurance	23,487	28,890	6
7	Other Prepaid Expenses	30,884	30,884	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,675,506	$ 1,699,015	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,577,420	13
14	Buildings, at Historical Cost		4,307,820	14
15	Leasehold Improvements, at Historical Cost	17,348	45,896	15
16	Equipment, at Historical Cost	67,500	240,686	16
17	Accumulated Depreciation (book methods)	(44,336)	(232,629)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		57,914	21
22	Other Long-Term Assets (spe Loan Fees		203,485	22
23	Other(specify): Deposits	2,000	2,000	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 42,512	$ 6,202,592	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,718,018	$ 7,901,607	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 851,144	$ 860,193	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	165,112	165,112	30
31	Accrued Taxes Payable (excluding real estate taxes)	35,593	35,593	31
32	Accrued Real Estate Taxes(Sch.IX-B)		143,335	32
33	Accrued Interest Payable		7,939	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	12,184	12,184	35
	Other Current Liabilities(specify):			
36	Accrued Expenses	537,208	548,408	36
37	Accrued Rent	631,334		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,232,575	$ 1,772,764	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,200,591	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to Bravo Holding Company	3,255,009	3,255,009	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,255,009	$ 14,455,600	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,487,584	$ 16,228,364	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,769,566)	$ (8,326,757)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,718,018	$ 7,901,607	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Rosewood Care Ctr St Charles # 0049320 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**	$ (3,309,746)	1
2	Restatements (describe):		2
3	**Prior period post closing adjustments**	6,291	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,303,455)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(466,111)	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)**	$ (466,111)	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)**	$ (3,769,566)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr St Charles # 0049320 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	$ 9,822,663	1
2	Discounts and Allowances for all Levels	(1,967,215)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,855,448	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	271,200	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 271,200	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	3,900	13
14	Non-Patient Meals	1,184	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	44,028	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 49,112	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,717	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,717	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Attached Schedule 19A	462	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 462	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,178,939	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,273,412	31
32	Health Care	3,747,022	32
33	General Administration	1,357,635	33
	B. Capital Expense		
34	Ownership	1,330,734	34
	C. Ancillary Expense		
35	Special Cost Centers	710,670	35
36	Provider Participation Fee	225,577	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,645,050	40
41	**Income before Income Taxes (line 30 minus line 40)****	(466,111)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (466,111)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,678,117	44
45	Private Pay - Net Inpatient Revenue	1,729,905	45
46	Medicare - Net Inpatient Revenue	2,671,968	46
47	Other-(specify) **Insurance/Managed Care**	775,458	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,855,448	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 St Charles

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

Schedule 19A

Other Revenue:

Vending Income	**382**
Vendor Discount	**3,821**
Miscellaneous	**(3,741)**
Total Other Revenue	**462**

Facility Name & ID Number Rosewood Care Ctr St Charles # 0049320 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	1,991	2,278	$ 70,308	$ 30.86	1
2	Assistant Director of Nursing	1,832	1,936	54,502	28.15	2
3	Registered Nurses	36,676	39,270	1,049,261	26.72	3
4	Licensed Practical Nurses	8,276	9,177	198,633	21.64	4
5	CNAs & Orderlies	77,251	81,984	931,077	11.36	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,184	2,397	30,154	12.58	8
9	Activity Director	2,630	2,866	41,229	14.39	9
10	Activity Assistants	3,073	3,316	31,704	9.56	10
11	Social Service Workers	3,476	3,712	55,145	14.86	11
12	Dietician					12
13	Food Service Supervisor	2,069	2,346	37,437	15.96	13
14	Head Cook					14
15	Cook Helpers/Assistants	23,256	25,061	222,266	8.87	15
16	Dishwashers					16
17	Maintenance Workers	2,300	2,450	36,897	15.06	17
18	Housekeepers	1,316	2,262	20,990	9.28	18
19	Laundry	219	405	3,978	9.82	19
20	Administrator	2,160	2,398	108,369	45.19	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,633	10,487	110,962	10.58	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	3,477	3,701	43,660	11.80	31
32	Other Health Care(specify)					32
33	Other(specify) See Sch 20A	11,526	12,609	339,868	26.95	33
34	TOTAL (lines 1 - 33)	193,345	208,655	$ 3,386,440 *	$ 16.23	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	$ 11,186	L1, C3	35
36	Medical Director	Monthly	3,281	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,876	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	1,012	L11, C3	44
45	Social Service Consultant	Monthly	1,600	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 23,955		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	17	$ 829	L10, C3	50
51	Licensed Practical Nurses	107	3,967	L10, C3	51
52	Certified Nurse Assistants/Aides	38	789	L10, C3	52
53	TOTAL (lines 50 - 52)	162	$ 5,585		53

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Care Ctr St Charles

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		**2,263**	**2,448**	**74,498**	30.43
Case Manager		**2,658**	**2,997**	**105,424**	35.18
Ward Clerk		**2,389**	**2,727**	**64,163**	23.53
Marketing		**4,216**	**4,437**	**95,783**	21.59
	TOTAL	**11,526**	**12,609**	**339,868**	

Facility Name & ID Number Rosewood Care Ctr St Charles # 0049320 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ivy Gleeson	Administrator	0	$ 108,369
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 108,369

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	231,839
TOTAL (agree to Schedule V, line 17, col. 3)	$ 369,839
(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	1,411
Odessa Healthcare	Consultant	68,400
Claims Administration Services, Inc.	Related Party Legal Fees	5,264
Daniel Maher	Legal Fees	2,951
Kelly, Olson, Michod, DeHaan	Legal Fees	5,578
Mulherin, Rehfeldt & Varchetto	Legal Fees	2,108
Marsh USA	Bond Fee	100
Assurance Agency	Bond Fee	250
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 89,182

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 92,485
Unemployment Compensation Insurance	41,377
FICA Taxes	255,609
Employee Health Insurance	50,809
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	2,666
Employee Uniforms	1,334
Employee Physicals	2,070
Employee Drug Tests	908
Tuition Reimbursement	1,472
401K Expense	1,892
Recruitment Fees	10,000
TOTAL (agree to Schedule V, line 22, col.8)	$ 460,622

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 265)	3,450
Patient Background Checks	
Misc. Dues/Subscriptions/Fees	723
IHCA Dues	1,921
Misc. Licenses	1,342
Home Office Allocation	7,510
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,822

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Home Office Allocation	9,922
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,922

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr St Charles # 0049320 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 St Charles # 0049320 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. **1,921 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. $ **59,437** 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. $ **225,577**
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. $ **1,566**

(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.