		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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0049130

Facility Name: Rosewood Care Center Of Joliet

Address: 3401 Hennepin Drive (Number) Joliet (City) 60431 (Zip Code)

County: Will

Telephone Number: (815) 436-5900 **Fax #** (815) 436-0743

HFS ID Number: [redacted]

Date of Initial License for Current Owners: 11/1/2007

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: Steven N. Lavenda **Telephone Number:** ([redacted]
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 07/01/15 to 06/30/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) _____
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,920	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,920	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	9,203	10,767	8,851	28,821	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,203	10,767	8,851	28,821	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.62%

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]

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 11/01/07

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/07 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 58 and days of care provided 6,217

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: 6/30/2016 Fiscal Year: 6/30/2016

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	26,111	4,745	371,712	402,568		402,568	404	402,972			1
2	Food Purchase		206,073		206,073		206,073	(3,864)	202,209			2
3	Housekeeping		22,442	179,511	201,953		201,953		201,953			3
4	Laundry			119,674	119,674		119,674		119,674			4
5	Heat and Other Utilities			142,431	142,431		142,431	(7,791)	134,640			5
6	Maintenance	27,338	8,892	268,248	304,478		304,478	(49,820)	254,658			6
7	Other (specify):*							4,885	4,885			7
8	TOTAL General Services	53,449	242,152	1,081,576	1,377,177		1,377,177	(56,186)	1,320,991			8
	B. Health Care and Programs											
9	Medical Director			16,500	16,500		16,500		16,500			9
10	Nursing and Medical Records	2,116,036	245,938	279,189	2,641,163		2,641,163	25,717	2,666,880			10
10a	Therapy	101,584	2,298		103,882		103,882		103,882			10a
11	Activities	78,629	5,781	428	84,838		84,838		84,838			11
12	Social Services	58,546	150	2,200	60,896		60,896		60,896			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							2,515	2,515			15
16	TOTAL Health Care and Programs	2,354,795	254,167	298,317	2,907,279		2,907,279	28,232	2,935,511			16
	C. General Administration											
17	Administrative	91,830		388,876	480,706		480,706	(342,933)	137,773			17
18	Directors Fees											18
19	Professional Services			70,275	70,275		70,275	62,364	132,639			19
20	Dues, Fees, Subscriptions & Promotions			16,552	16,552		16,552	(494)	16,058			20
21	Clerical & General Office Expenses	79,687	28,648	608,658	716,993		716,993	(399,172)	317,821			21
22	Employee Benefits & Payroll Taxes			371,871	371,871		371,871		371,871			22
23	Inservice Training & Education											23
24	Travel and Seminar			757	757		757	1,080	1,837			24
25	Other Admin. Staff Transportation			8,224	8,224		8,224	4,731	12,955			25
26	Insurance-Prop.Liab.Malpractice			62,859	62,859		62,859	13,562	76,421			26
27	Other (specify):*							22,703	22,703			27
28	TOTAL General Administration	171,517	28,648	1,528,072	1,728,237		1,728,237	(638,158)	1,090,079			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,579,761	524,967	2,907,965	6,012,693		6,012,693	(666,113)	5,346,580			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
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 Center Of Joliet #0049130 **Report Period Beginning:** 07/01/15 **Ending:** 06/30/16

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			13,306	13,306		13,306	171,220	184,526			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			75,271	75,271		75,271	334,795	410,066			32
33	Real Estate Taxes							120,804	120,804			33
34	Rent-Facility & Grounds			1,188,683	1,188,683		1,188,683	(1,172,794)	15,889			34
35	Rent-Equipment & Vehicles							24	24			35
36	Other (specify):*			13,767	13,767		13,767	47,193	60,960			36
37	**TOTAL Ownership**			1,291,027	1,291,027		1,291,027	(498,758)	792,269			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		403,277	812,143	1,215,420		1,215,420		1,215,420			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			208,926	208,926		208,926		208,926			42
43	Other (specify):*	103,593		3,495	107,088		107,088	(107,088)	(0)			43
44	**TOTAL Special Cost Centers**	103,593	403,277	1,024,564	1,531,434		1,531,434	(107,088)	1,424,346			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,683,354	928,244	5,223,556	8,835,154		8,835,154	(1,271,959)	7,563,195			45

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	(3,094)	02		4
5	Telephone, TV & Radio in Resident Rooms	(8,166)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(3,111)	30		9
10	Interest and Other Investment Income	(229,650)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(770)	02		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	(45)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(547,833)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(463)	20		28
29	Other-Attach Schedule	(210,481)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,003,613)		$	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)	(268,346)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (268,346)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,271,959)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Rosewood Care Center Of Joliet

ID# 0049130

Report Period Beginning: 07/01/15

Ending: 06/30/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Salary	$ (103,593)	43	1
2	Bank Charges	(3,260)	21	2
3	Marketing	(3,495)	43	3
4	Vendor Discount	(6,391)	21	4
5	Vendor Late Charges	(21,753)	21	5
6	Midcap Line of Credit Fees	(13,767)	36	6
7	Building Co. - Audit Fees	(4,100)	19	7
8	Building Co. - Professional Fees	(883)	19	8
9	Building Co. - Bank Fees	(16,716)	21	9
10	Building Co. - Amortization Loan Fee	(5,708)	36	10
11	PAC Dues	(2,588)	20	11
12	Capitalized R&M	(15,740)	06	12
13	Non-Allowable Travel	(6,951)	25	13
14	Building Co. - Gain/Loss on Asset Sale	(258)	36	14
15	Miscellaneous Income	(925)	21	15
16	Non-Allowable Legal	(4,353)	19	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**	(210,481)		49

Rosewood Care Center Of Joliet

ID# 0049130

Report Period Beginning: 07/01/15

Ending: 06/30/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 **Report Period Beginning:** 07/01/15 **Ending:** 06/30/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary				404								404	1
2	Food Purchase	(3,864)											(3,864)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(8,166)		138				237					(7,791)	5
6	Maintenance	(15,740)		84				(34,164)					(49,820)	6
7	Other (specify):*				43			4,842					4,885	7
8	**TOTAL General Services**	(27,770)		222	447			(29,085)					(56,186)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				25,717								25,717	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				2,515								2,515	15
16	**TOTAL Health Care and Programs**				28,232								28,232	16
	C. General Administration													
17	Administrative			(250,876)	(98,269)	6,212							(342,933)	17
18	Directors Fees													18
19	Professional Services	(9,336)	4,983	100	73	16,535	49,894	115					62,364	19
20	Fees, Subscriptions & Promotions	(3,051)		2,031	2	212	203	110					(494)	20
21	Clerical & General Office Expenses	(596,923)	23,916	127,441	405	286	45,286	416					(399,172)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			417	147	255	260						1,080	24
25	Other Admin. Staff Transportation	(6,951)		2,109	2,666	1,291	2,785	2,831					4,731	25
26	Insurance-Prop.Liab.Malpractice		8,956	3,655				951					13,562	26
27	Other (specify):*			16,840	3,197		2,666						22,703	27
28	**TOTAL General Administration**	(616,261)	37,855	(98,284)	(91,780)	24,792	101,095	4,424					(638,158)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(644,031)	37,855	(98,062)	(63,101)	24,792	101,095	(24,661)					(666,113)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 **Report Period Beginning:** 07/01/15 **Ending:** 06/30/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(3,111)	159,475	13,795				1,061					171,220	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(229,650)	549,746	15,786		(1,087)							334,795	32
33	Real Estate Taxes		120,804										120,804	33
34	Rent-Facility & Grounds		(1,185,623)	12,829									(1,172,794)	34
35	Rent-Equipment & Vehicles				8	5		11					24	35
36	Other (specify):*	(19,733)	66,926										47,193	36
37	TOTAL Ownership	(252,494)	(288,672)	42,409	8	(1,082)		1,071					(498,758)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(107,088)											(107,088)	43
44	TOTAL Special Cost Centers	(107,088)											(107,088)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,003,613)	(250,817)	(55,652)	(63,093)	23,711	101,095	(23,589)					(1,271,959)	45

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

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
See Page 6 - Supplemental		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	34	Rental Income	$ 1,185,623	Joliet Real Estate Holding, LLC		$	$ (1,185,623)	1
2	V	32	Interest Income - Escrow	33	Joliet Real Estate Holding, LLC			(33)	2
3	V	19	Audit Fees		Joliet Real Estate Holding, LLC		4,100	4,100	3
4	V	19	Professional Fees		Joliet Real Estate Holding, LLC		883	883	4
5	V	21	Bank Charges		Joliet Real Estate Holding, LLC		16,716	16,716	5
6	V	32	Interest Expense - HUD Mortgage		Joliet Real Estate Holding, LLC		549,779	549,779	6
7	V	36	Interest Expense - HUD MIP		Joliet Real Estate Holding, LLC		60,960	60,960	7
8	V	33	Real Estate Tax		Joliet Real Estate Holding, LLC		120,804	120,804	8
9	V	30	Depreciation		Joliet Real Estate Holding, LLC		159,475	159,475	9
10	V	36	Amortization Loan Fee		Joliet Real Estate Holding, LLC		5,708	5,708	10
11	V	21	Base Admin Fee (Page 6A)		Joliet Real Estate Holding, LLC		7,200	7,200	11
12	V	26	Insurance Expense - Property		Joliet Real Estate Holding, LLC		8,956	8,956	12
13	V	36	Gain/Loss on Asset Sale		Joliet Real Estate Holding, LLC		258	258	13
14	Total			$ 1,185,656			$ 934,839	$ * (250,817)	14

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	$	MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	$ 138	$ 138	15
16	V	6	MAINTENANCE EXPENSE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	84	84	16
17	V	19	PROFESSIONAL FEES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	100	100	17
18	V	20	DUES, SUBSCRIPTIONS, LICENSES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	2,031	2,031	18
19	V	21	OFFICE SALARIES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	106,028	106,028	19
20	V	21	OFFICE EXPENSES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	28,614	28,614	20
21	V	24	SEMINAR		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	417	417	21
22	V	25	TRAVEL EXPENSE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	2,109	2,109	22
23	V	26	INSURANCE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	3,655	3,655	23
24	V	27	EMPLOYEE BENEFITS		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	16,840	16,840	24
25	V	30	DEPRECIATION		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	13,795	13,795	25
26	V	32	INTEREST		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	15,786	15,786	26
27	V	34	BUILDING RENT		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	12,829	12,829	27
28	V								28
29	V	17	ADMINISTRATIVE FEE	250,876	MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%		(250,876)	29
30	V	21	ADMINISTRATIVE FEE (BLDG CO)	7,200	MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%		(7,200)	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			$ 258,076			$ 202,424	$ * (55,652)	39

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

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 SALARY	$	BRAVO NURSING HOME SERVICES, INC.	100.00%	$ 404	$ 404	15
16	V	7	DIETARY BENEFITS		BRAVO NURSING HOME SERVICES, INC.	100.00%	43	43	16
17	V	10	CORPORATE RN SALARIES		BRAVO NURSING HOME SERVICES, INC.	100.00%	25,717	25,717	17
18	V	15	CORPORATE RN SALARIES BENEFITS		BRAVO NURSING HOME SERVICES, INC.	100.00%	2,515	2,515	18
19	V	17	ADMINISTRATIVE SALARIES		BRAVO NURSING HOME SERVICES, INC.	100.00%	39,731	39,731	19
20	V	19	PROFESSIONAL FEES		BRAVO NURSING HOME SERVICES, INC.	100.00%	73	73	20
21	V	20	DUES & SUBSCRIPTIONS		BRAVO NURSING HOME SERVICES, INC.	100.00%	2	2	21
22	V	21	OFFICE EXPENSES		BRAVO NURSING HOME SERVICES, INC.	100.00%	405	405	22
23	V	24	SEMINAR & LODGING EXPENSE		BRAVO NURSING HOME SERVICES, INC.	100.00%	147	147	23
24	V	25	AUTO EXPENSE		BRAVO NURSING HOME SERVICES, INC.	100.00%	2,666	2,666	24
25	V	27	ADMINISTRATIVE & OFFICE BENEFITS		BRAVO NURSING HOME SERVICES, INC.	100.00%	3,197	3,197	25
26	V	35	AUTO LEASE		BRAVO NURSING HOME SERVICES, INC.	100.00%	8	8	26
27	V								27
28	V	17	ADMINISTRATIVE FEE	138,000	BRAVO NURSING HOME SERVICES, INC.	100.00%		(138,000)	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			$ 138,000			$ 74,907	$ * (63,093)	39

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	CONSULTING FEES	$	BRAVO HOLDING COMPANY	100.00%	$ 6,212	$ 6,212	15
16	V	19	PROFESSIONAL FEES		BRAVO HOLDING COMPANY	100.00%	16,535	16,535	16
17	V	20	DUES & SUBSCRIPTIONS		BRAVO HOLDING COMPANY	100.00%	212	212	17
18	V	21	OFFICE EXPENSE		BRAVO HOLDING COMPANY	100.00%	286	286	18
19	V	24	SEMINAR EXPENSE		BRAVO HOLDING COMPANY	100.00%	255	255	19
20	V	25	AUTO & TRAVEL EXPENSE		BRAVO HOLDING COMPANY	100.00%	1,291	1,291	20
21	V	32	INTEREST		BRAVO HOLDING COMPANY	100.00%	(1,087)	(1,087)	21
22	V	35	AUTO RENTAL		BRAVO HOLDING COMPANY	100.00%	5	5	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			$			$ 23,711	$ * 23,711	39

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

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 FEES	$	CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	$ 1,283	$ 1,283	15
16	V	20	LICENSES		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	203	203	16
17	V	21	OFFICE SALARIES		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	44,348	44,348	17
18	V	21	OFFICE EXPENSE		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	938	938	18
19	V	24	SEMINAR		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	260	260	19
20	V	25	AUTO / TRAVEL EXPENSE		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	2,785	2,785	20
21	V	27	EMPLOYEE BENEFITS		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	2,666	2,666	21
22	V								22
23	V	19	PROFESSIONAL FEES	(48,611)	CLAIMS ADMINISTRATION SERVICES, LLC	100.00%		48,611	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			$ (48,611)			$ 52,484	$ * 101,095	39

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

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.	100.00%	$ 237	$ 237	15
16	V	6	MAINTENANCE SALARY		SENIOR LIVING SERVICES, INC.	100.00%	34,150	34,150	16
17	V	6	MAINTENANCE EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	3,465	3,465	17
18	V	7	MAINTENANCE BENEFITS		SENIOR LIVING SERVICES, INC.	100.00%	4,842	4,842	18
19	V	19	PROFESSIONAL FEES		SENIOR LIVING SERVICES, INC.	100.00%	115	115	19
20	V	20	LICENSES		SENIOR LIVING SERVICES, INC.	100.00%	110	110	20
21	V	21	OFFICE EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	416	416	21
22	V	25	AUTO / TRAVEL EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	2,831	2,831	22
23	V	26	INSURANCE		SENIOR LIVING SERVICES, INC.	100.00%	951	951	23
24	V	30	DEPRECIATION		SENIOR LIVING SERVICES, INC.	100.00%	1,061	1,061	24
25	V	35	AUTO LEASE		SENIOR LIVING SERVICES, INC.	100.00%	11	11	25
26	V	6	MAINTENANCE SUPPLIES		SENIOR LIVING SERVICES, INC.	100.00%	1,189	1,189	26
27	V								27
28	V	6	MAINTENANCE SERVICES	72,968	SENIOR LIVING SERVICES, INC.	100.00%		(72,968)	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			$ 72,968			$ 49,379	$ * (23,589)	39

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

VII. RELATED PARTIES (continued)

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

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

1 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								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			$			$	$ *	39

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

VII. RELATED PARTIES (continued)

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

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

1 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								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			$			$	$ *	39

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

VII. RELATED PARTIES (continued)

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

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

1 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								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			$			$	$ *	39

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

VII. RELATED PARTIES (continued)

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

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

1 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								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			$			$	$ *	39

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	Hinde Feiner	50.00%	Bravo Care of Alton, Inc.	Alton, IL	Joliet Real Estate Holding, LLC		Lessor	1
2	Hillel Yampol	50.00%	Bravo Care of East Peoria, Inc.	East Peoria, IL	Bravo Administrative Services, Inc.	St. Louis, MO	Administration	2
3			Bravo Care of Edwardsville, Inc.	Edwardsville, IL	Bravo Holding Company, Inc.	St. Louis, MO	Holding Company	3
4			Bravo Care of Elgin, Inc.	Elgin, IL	Bravo Nursing Home Services, Inc.	St. Louis, MO	Management	4
5			Bravo Care of Galesburg, Inc.	Galesburg, IL	Bravo Team Health, Inc.	St. Louis, MO	Human Resources	5
6			Bravo Care of Inverness, Inc.	Inverness, IL	Claims Administration Services, LL	St. Louis, MO	Legal Services	6
7			Bravo Care of Moline, Inc.	Moline, IL	Senior Living Services, Inc.	St. Louis, MO	Building Services	7
8			Bravo Care of Northbrook, Inc.	Northbrook, IL	Midwest Administrative Services, I	St. Louis, MO	Administration	8
9			Bravo Care of Peoria, Inc.	Peoria, IL	Bravo Care of Wood River, Inc.	Wood River, IL	Supportive Living Facility	9
10			Bravo Care of Rockford, Inc.	Rockford, IL	Rosewood Home Health Services, I	Edwardsville, IL	Home Health	10
11			Bravo Care of St. Charles, Inc.	St. Charles, IL				11
12			Bravo Care of St. Louis, Inc.	St. Louis, MO				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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

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								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

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%	See Attached	1.24	6.21%	Salary	$ 6,212	17-07	1
2	Hillel Yampol	Owner	Administrative	50.00%	See Attached	1.24	6.21%	Salary	1,409	17-07	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 7,621		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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

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, IN
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	PAT. DAYS	463,927	14	$ 2,224	$	28,821	$ 138	1
2	6	MAINTENANCE EXPENSE	PAT. DAYS	463,927	14	1,345		28,821	84	2
3	19	PROFESSIONAL FEES	PAT. DAYS	463,927	14	1,614		28,821	100	3
4	20	DUES, SUBSCRIPTIONS, LICEN	PAT. DAYS	463,927	14	32,685		28,821	2,031	4
5	21	OFFICE SALARIES	PAT. DAYS	463,927	14	1,706,712	1,706,712	28,821	106,028	5
6	21	OFFICE EXPENSES	PAT. DAYS	463,927	14	460,588		28,821	28,614	6
7	24	SEMINAR	PAT. DAYS	463,927	14	6,706		28,821	417	7
8	25	TRAVEL EXPENSE	PAT. DAYS	463,927	14	33,946		28,821	2,109	8
9	26	INSURANCE	PAT. DAYS	463,927	14	58,834		28,821	3,655	9
10	27	EMPLOYEE BENEFITS	PAT. DAYS	463,927	14	271,068		28,821	16,840	10
11	30	DEPRECIATION	PAT. DAYS	463,927	14	222,055		28,821	13,795	11
12	32	INTEREST	PAT. DAYS	463,927	14	254,102		28,821	15,786	12
13	34	BUILDING RENT	PAT. DAYS	463,927	14	206,500		28,821	12,829	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					$ 3,258,379	$ 1,706,712		$ 202,426	25

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

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, 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 SALARY	PAT. DAYS	463,927	14	$ 6,505	$ 6,505	28,821	$ 404	1
2	7	DIETARY BENEFITS	PAT. DAYS	463,927	14	687		28,821	43	2
3	10	CORPORATE RN SALARIES	PAT. DAYS	463,927	14	413,960	413,960	28,821	25,717	3
4	15	CORPORATE RN SALARIES BE	PAT. DAYS	463,927	14	40,484		28,821	2,515	4
5	17	ADMINISTRATIVE SALARIES	PAT. DAYS	463,927	14	639,544	639,544	28,821	39,731	5
6	19	PROFESSIONAL FEES	PAT. DAYS	463,927	14	1,170		28,821	73	6
7	20	DUES & SUBSCRIPTIONS	PAT. DAYS	463,927	14	27		28,821	2	7
8	21	OFFICE EXPENSES	PAT. DAYS	463,927	14	6,517		28,821	405	8
9	24	SEMINAR & LODGING EXPEN	PAT. DAYS	463,927	14	2,370		28,821	147	9
10	25	AUTO EXPENSE	PAT. DAYS	463,927	14	42,910		28,821	2,666	10
11	27	ADMINISTRATIVE & OFFICE I	PAT. DAYS	463,927	14	51,458		28,821	3,197	11
12	35	AUTO LEASE	PAT. DAYS	463,927	14	133		28,821	8	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,205,766	$ 1,060,009		$ 74,908	25

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	17	CONSULTING FEES	PATIENT DAYS	463,927	14	$ 100,000	$	28,821	$ 6,212	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	463,927	14	266,160		28,821	16,535	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	463,927	14	3,410		28,821	212	3
4	21	OFFICE EXPENSE	PATIENT DAYS	463,927	14	4,609		28,821	286	4
5	24	SEMINAR EXPENSE	PATIENT DAYS	463,927	14	4,112		28,821	255	5
6	25	AUTO & TRAVEL EXPENSE	PATIENT DAYS	463,927	14	20,788		28,821	1,291	6
7	32	INTEREST	PATIENT DAYS	463,927	14	(17,495)		28,821	(1,087)	7
8	35	AUTO RENTAL	PATIENT DAYS	463,927	14	85		28,821	5	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					$ 381,668	$		$ 23,709	25

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

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 FEES	ACTUAL FEES	667,999	13	$ 6,309	$	135,840	$ 1,283	1
2	20	LICENSES	ACTUAL FEES	667,999	13	1,000		135,840	203	2
3	21	OFFICE SALARIES	ACTUAL FEES	667,999	13	218,085	218,085	135,840	44,348	3
4	21	OFFICE EXPENSE	ACTUAL FEES	667,999	13	4,612		135,840	938	4
5	24	SEMINAR	ACTUAL FEES	667,999	13	1,281		135,840	260	5
6	25	AUTO / TRAVEL EXPENSE	ACTUAL FEES	667,999	13	13,694		135,840	2,785	6
7	27	EMPLOYEE BENEFITS	ACTUAL FEES	667,999	13	13,112		135,840	2,666	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					$ 258,092	$ 218,085		$ 52,483	25

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	ACTUAL FEES	929,714	14	$ 3,017	$	72,968	$ 237	1
2	6	MAINTENANCE SALARY	ACTUAL FEES	929,714	14	435,123	435,123	72,968	34,150	2
3	6	MAINTENANCE EXPENSE	ACTUAL FEES	929,714	14	44,153		72,968	3,465	3
4	7	MAINTENANCE BENEFITS	ACTUAL FEES	929,714	14	61,694		72,968	4,842	4
5	19	PROFESSIONAL FEES	ACTUAL FEES	929,714	14	1,467		72,968	115	5
6	20	LICENSES	ACTUAL FEES	929,714	14	1,402		72,968	110	6
7	21	OFFICE EXPENSE	ACTUAL FEES	929,714	14	5,306		72,968	416	7
8	25	AUTO / TRAVEL EXPENSE	ACTUAL FEES	929,714	14	36,073		72,968	2,831	8
9	26	INSURANCE	ACTUAL FEES	929,714	14	12,121		72,968	951	9
10	30	DEPRECIATION	ACTUAL FEES	929,714	14	13,517		72,968	1,061	10
11	35	AUTO LEASE	ACTUAL FEES	929,714	14	135		72,968	11	11
12	6	MAINTENANCE SUPPLIES	DIRECT ALLOCATION		13	6,541			1,189	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					$ 620,549	$ 435,123		$ 49,378	25

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	$91,297.26	4/1/04	$ 14,104,500	$ 12,229,732	5/1/39	0.0450	$ 549,779	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Midcap		X	Revolving Line of Credit		8/1/09			12/31/15	5.0000	75,271	6
7	Alloc from Midwest Admin Services		X								15,786	7
8												8
9	TOTAL Facility Related				91297.26		$ 14,104,500	$ 12,229,732			$ 640,836	9
	B. Non-Facility Related*											
10	Interest Inc - Building Co		X								(33)	10
11	Alloc from Bravo Holding Co		X								(1,087)	11
12	Interest Inc - Bravo Holding		X								(229,650)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (230,770)	14
15	TOTALS (line 9+line14)						$ 14,104,500	$ 12,229,732			$ 410,066	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 60,960 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.)**

**** 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 Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* 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 Center Of Joliet **#** 0049130 **Report Period Beginning:** 07/01/15 **Ending:** 06/30/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 120,555	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.)		$ 118,085	2
3. Under or (over) accrual (line 2 minus line 1).		$ (2,470)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 123,274	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.		$ 120,804	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	99,667	8
	2012	109,912	9
	2013	116,736	10
	2014	118,435	11
	2015	117,736	12

Accrual based on prior year tax bill.

The expense on line 2 is the second installment of 2014 and first installment of 2015 tax bills.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rosewood Care Center Of Joliet COUNTY Will

FACILITY IDPH LICENSE NUMBER 0049130

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-03-26-203-123-0000	Nursing Home	$ 117,735.66	$ 117,735.66
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 117,735.66	$ 117,735.66

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rosewood Care Center Of Joliet COUNTY Will

FACILITY IDPH LICENSE NUMBER 0049130

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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 _____ 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	203,860	1990	$ 213,780	1
2					2
3	TOTALS	203,860		$ 213,780	3

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		1990	1990	$ 3,475,917	$ 159,475	40	$ 86,898	$ (72,577)	$ 2,259,346	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

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			$	$		$	$	$	37
38									38
39									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	Related Building Company (Pages 12F & 12G)		950,140			49,994	49,994	699,622	67
68	Related Party Allocations (Pages 12H & 12I)								68
69	Financial Statement Depreciation			13,306			(13,306)		69
70	TOTAL (lines 4 thru 69)		$ 4,426,057	$ 172,781		$ 136,892	$ (35,889)	$ 2,958,968	70

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	
1	Totals from Page 12A, Carried Forward		$ 4,426,057	$ 172,781		$ 136,892	$ (35,889)	$ 2,958,968	1
2	Wallpaper In Assisted Dining Room	2013	5,785		20	826	826	2,547	2
3	Wallpaper-600&100 Hall,Crossover Hall,Lobby,Hall By Laundry	2014	10,570		20	1,510	1,510	3,331	3
4	Generator Repair	2015	3,850		20	193	193	193	4
5	Remove Old Piping/Install New - Rm 409, Reset Dry Valve	2015	5,035		20	252	252	252	5
6	New Accelerator Installation, Replaced 4" Dry Valve	2016	6,855		20	343	343	343	6
7									7
8	Continued from 12G-Building Company-Leasehold Improvements								8
9	Repaired Concrete Curb	2015	2,800		25	84	84	84	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	TOTAL (lines 1 thru 33)		$ 4,460,952	$ 172,781		$ 140,100	$ (32,681)	$ 2,965,718	34

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	
1	Totals from Page 12B, Carried Forward		$ 4,460,952	$ 172,781		$ 140,100	$ (32,681)	$ 2,965,718	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,460,952	$ 172,781		$ 140,100	$ (32,681)	$ 2,965,718	34

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	
1	Totals from Page 12C, Carried Forward		$ 4,460,952	$ 172,781		$ 140,100	$ (32,681)	$ 2,965,718	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,460,952	$ 172,781		$ 140,100	$ (32,681)	$ 2,965,718	34

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	
1	Totals from Page 12D, Carried Forward		$ 4,460,952	$ 172,781		$ 140,100	$ (32,681)	$ 2,965,718	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,460,952	$ 172,781		$ 140,100	$ (32,681)	$ 2,965,718	34

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	
1	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Storm Sewer	1991	32,675		25	653	653	32,675	9
10	Lawn Sprinkler	1991	13,190		25	263	263	13,190	10
11	Landscaping	1991	60,077		25	1,202	1,202	60,077	11
12	Mass Grading	1991	54,747		25	1,095	1,095	54,747	12
13	Asphalt Paving	1991	48,390		25	967	967	48,380	13
14	Sanitary Sewer	1991	8,069		25	161	161	8,069	14
15	Water Line	1991	15,500		25	310	310	15,500	15
16	Driveway & Sidewalks	1991	55,932		25	1,119	1,119	55,932	16
17	Walk-In Cooler Refrigeration	1991	6,888		10			6,688	17
18	Exhaust & Air Hood	1991	4,670		10			4,670	18
19	Generator Accessories	1991	15,764		10			15,764	19
20	6 Stainless Doors	1991	2,685		10			1,685	20
21	Monument Sign	1991	3,193		10			3,193	21
22	Nurse Call Station	1991	28,217		10			28,217	22
23	Fire Alarm System	1991	15,724		10			15,724	23
24	Door Alarm	1991	5,773		10			5,773	24
25	Public Address	1991	5,022		10			5,022	25
26	Hot Water Boiler	1991	6,792		10			6,792	26
27	Hot Watter Heater	1991	7,841		10			7,841	27
28	Seal & Stripe New Parking Spaces	2003	11,439		25	458	458	5,835	28
29	Roof Replacement	2005	6,944		40	174	174	1,925	29
30	Water Softener	2005	5,116		10	85	85	5,116	30
31	Door Closers	2005	5,496		10	183	183	5,496	31
32	Patient Rooms Sinks	2006	23,683		10	1,579	1,579	23,683	32
33	Satellite System	2006	9,002		10	900	900	8,701	33
34	TOTAL (lines 1 thru 33)		$ 452,829	$		$ 9,148	$ 9,148	$ 440,695	34

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	
1	Totals from Page 12F, Carried Forward		$ 452,829	$		$ 9,148	$ 9,148	$ 440,695	1
2	Seal & Patch Parking Lot	2006	5,055		25	202	202	1,954	2
3	Heat Pumps	2007	3,004		10	300	300	2,627	3
4	Nurse Call System	2008	71,367		10	7,137	7,137	59,884	4
5	Fire Alarm System	2008	54,919		10	5,492	5,492	46,389	5
6	Carpet	2008	4,579		10	458	458	3,702	6
7	Fire Alarm System	2008	6,381		10	638	638	5,105	7
8	Nurse Call System	2008	14,550		10	1,455	1,455	11,519	8
9	Telephone System	2008	22,919		10	2,292	2,292	18,909	9
10	Concrete Pad for Dumpster	2009	4,350		10	435	435	3,081	10
11	Grease Trap	2009	6,115		10	612	612	4,485	11
12	Sprinkler System Pipe	2009	3,715		10	372	372	2,571	12
13	Parking Lot Seal & Stripe	2009	11,518		25	461	461	3,200	13
14	Cooling Tower	2010	88,905		10	8,891	8,891	55,567	14
15	Sprinkler Pipe	2010	11,181		10	1,118	1,118	6,988	15
16	Cooling Tower Addition	2010	1,350		10	135	135	810	16
17	Sprinkler	2010	3,884		10	388	388	2,200	17
18	Water Heater	2011	6,494		10	649	649	3,138	18
19	Paving / Concrete	2012	52,000		25	2,080	2,080	7,921	19
20	Cooling Tower Starter	2012	3,178		10	318	318	1,219	20
21	HVAC	2012	3,359		40	84	84	336	21
22	Exit Doors 1, 8, and 10, and Beverage Room Door	2013	8,675		40	217	217	723	22
23	Sprinkler Repairs	2013	10,441		40	261	261	848	23
24	Architectural Fee	2013	8,273		40	207	207	586	24
25	Engineering & Surveying	2013	7,600		25	304	304	856	25
26	Doors	2014	9,061		40	227	227	560	26
27	HVAC Improvements	2014	45,798		10	4,580	4,580	11,450	27
28	Seal Coating	2014	4,200		25	168	168	336	28
29	Asphalt Repair	2014	4,425		25	177	177	310	29
30	Parking Lot Light	2014	3,660		25	146	146	256	30
31	Electric Power Feeds - Baseboard Heaters in Dining Room	2014	3,485		10	349	349	581	31
32	Sewer Stoppage / Plumbing Repairs	2014	6,477		40	162	162	283	32
33	Walk-In Cooler	2015	6,393		10	533	533	533	33
34	TOTAL (lines 1 thru 33)		$ 950,140	$		$ 49,994	$ 49,994	$ 699,622	34

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	
1	Totals from Page 12H, Carried Forward		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	$ 328,421	$ 2,508	$ 31,384	$ 28,876	10	$ 266,138	71
72	Current Year Purchases	14,041		694	694	10	694	72
73	Fully Depreciated Assets	14,446	107	107		10	14,446	73
74								74
75	TOTALS	$ 356,908	$ 2,615	$ 32,185	$ 29,570		$ 281,278	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		Alloc Midwest Administrative Se	various	$ 43,854	$ 11,181	$ 11,181	$	5	$ 28,503	76
77		Alloc Senior Living Services, Inc.	various	11,748	1,061	1,061		5	10,992	77
78										78
79										79
80	TOTALS			$ 55,602	$ 12,242	$ 12,242	$		$ 39,495	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)	$ 5,087,242	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 187,638	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 184,527	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (3,111)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,286,491	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					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	Off-Site Storage				3,060			5
6	Allocated from Midwest Administrative Services, Inc.				12,829			6
7	TOTAL				$ 15,889 **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Bravo Nursing Home Services, Inc		$	$ 8	17
18	Allocated from Bravo Holding Company			5	18
19	Allocated from Senior Living Services, Inc.			11	19
20					20
21	TOTAL		$	$ 24	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.

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 325,440	$		$ 325,440	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			79,772			79,772	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			403,451			403,451	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				372,334		372,334	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					3,480	30,943		34,423	13
14	TOTAL			$		$ 812,143	$ 403,277		$ 1,215,420	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.

STATE OF ILLINOIS

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/16 (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	$ 1,180	$ 3,886	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,905,794	1,905,794	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	43,729	47,089	6
7	Other Prepaid Expenses	6,675	250,979	7
8	Accounts Receivable (owners or related parties)	4,673,502	6,810,107	8
9	Other(specify): See Attached Schedule	5,129	105,129	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,636,009	$ 9,122,984	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		213,780	13
14	Buildings, at Historical Cost		3,690,247	14
15	Leasehold Improvements, at Historical Cost	16,355	407,632	15
16	Equipment, at Historical Cost	54,849	838,178	16
17	Accumulated Depreciation (book methods)	(45,057)	(3,285,087)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):		109,369	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 26,147	$ 1,974,119	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,662,156	$ 11,097,103	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,481,408	$ 3,078,863	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	128,159	128,159	30
31	Accrued Taxes Payable (excluding real estate taxes)	147,004	147,004	31
32	Accrued Real Estate Taxes(Sch.IX-B)		123,274	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes		20,790	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	2,400,498	2,622,053	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,157,069	$ 6,120,143	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		12,229,732	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)**	$	$ 12,229,732	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,157,069	$ 18,349,875	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,505,087	$ (7,252,772)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,662,156	$ 11,097,103	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,046,102	1
2	Restatements (describe):		2
3	**Prior period post closing adjustments**	21,492	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,067,594	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(562,507)	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)**	$ (562,507)	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)**	$ 1,505,087	24 *

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	$ 7,895,373	1
2	Discounts and Allowances for all Levels	(2,866,579)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,028,794	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,388,565	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,388,565	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,125	13
14	Non-Patient Meals	3,094	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	435,320	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	46,928	19
20	Radiology and X-Ray	20,787	20
21	Other Medical Services	111,068	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 618,322	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	229,650	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 229,650	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	7,316	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,316	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,272,647	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,377,177	31
32	Health Care	2,907,279	32
33	General Administration	1,728,237	33
	B. Capital Expense		
34	Ownership	1,291,027	34
	C. Ancillary Expense		
35	Special Cost Centers	1,322,508	35
36	Provider Participation Fee	208,926	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,835,154	40
41	**Income before Income Taxes (line 30 minus line 40)****	(562,507)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (562,507)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,395,789	44
45	Private Pay - Net Inpatient Revenue	2,165,537	45
46	Medicare - Net Inpatient Revenue	1,165,988	46
47	Other-(specify) Insurance/Managed Care	301,480	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,028,794	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.**

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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	2,170	2,372	$ 80,648	$ 34.00	1
2	Assistant Director of Nursing	1,915	2,190	69,261	31.63	2
3	Registered Nurses	28,575	30,669	805,318	26.26	3
4	Licensed Practical Nurses	18,668	19,933	452,637	22.71	4
5	CNAs & Orderlies	53,998	57,532	664,954	11.56	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,336	8,750	101,584	11.61	8
9	Activity Director	2,120	2,336	48,779	20.88	9
10	Activity Assistants	3,328	3,467	29,850	8.61	10
11	Social Service Workers	4,270	4,745	58,546	12.34	11
12	Dietician					12
13	Food Service Supervisor	256	304	3,974	13.07	13
14	Head Cook					14
15	Cook Helpers/Assistants	2,036	2,320	22,137	9.54	15
16	Dishwashers					16
17	Maintenance Workers	2,169	2,283	27,338	11.97	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,912	1,952	91,830	47.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,552	6,942	79,687	11.48	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	3,838	4,232	43,218	10.21	31
32	Other Health Care(specify)					32
33	Other(specify)	4,126	4,344	103,593	23.85	33
34	TOTAL (lines 1 - 33)	144,269	154,371	$ 2,683,354 *	$ 17.38	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	$ 1,563	01-03	35
36	Medical Director	Monthly	16,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,319	10-03	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	428	11-03	44
45	Social Service Consultant	Monthly	2,200	12-03	45
46	Other(specify) Outsourced Dietary	Monthly	370,149	01-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 398,159		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	9	$ 809	10-03	50
51	Licensed Practical Nurses	182	7,994	10-03	51
52	Certified Nurse Assistants/Aides	10,984	263,067	10-03	52
53	TOTAL (lines 50 - 52)	11,175	$ 271,870		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
William Matjasich	Administrator	0	$ 91,830
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 91,830

B. Administrative - Other

Description	Amount
Base Management Fee - Bravo Nursing Home Services	$ 138,000
Base Admin Fee - Midwest Admin Services	36,000
Volume Admin Fee - Midwest Admin Services	214,876
TOTAL (agree to Schedule V, line 17, col. 3)	$ 388,876
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Larry Templin	Accounting	$ 1,856
Infinite Solutions	IT Solution Provider	20,756
Claims Administrative Services	Claims Management	(48,611)
Retirement Plan Associates	Financial Planning	147
Westlaw	Computer Consulting	981
See Attached	Legal Fees	14,221
George Rydman & Associates	Court Reporter	4,141
Randy Barinholtz	Court Reporter	278
Midwest Litigation Services	Court Reporter	1,034
US Legal Support, Inc	Court Reporter	77
McCorkle Litigation Services	Court Reporter	2,512
See Supplemental Schedule		72,882
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 70,274

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 71,338
Unemployment Compensation Insurance	39,078
FICA Taxes	201,179
Employee Health Insurance	48,425
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals & Vaccinations	1,630
Dental Insurance	2,311
Employee Relations	2,175
401K Expense	5,613
Employee Drug Tests	122
TOTAL (agree to Schedule V, line 22, col.8)	$ 371,871

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	914
Health Care Worker Background Check	
(Indicate # of checks performed 387)	4,266
Patient Background Checks	
Dues, Fees & Subscriptions	4,341
Alloc from Midwest Admin Services	2,031
Alloc from Bravo Nsg Home Services	2
Alloc from Bravo Holding Co	212
See Supplemental Schedule	313
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,059

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	757
Alloc from Midwest Admin Services	417
Alloc from Bravo Nsg Home Services	147
See Supplemental Schedule	515
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,836

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/15 Ending: 06/30/16

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA- $6,869**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **54,114** 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. $ **208,926**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **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. $ Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **3,094**

(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