		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: 0049031

Facility Name: Rosewood Care Center Of Edwardsville

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

County: Madison

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

HFS ID Number: [redacted]

Date of Initial License for Current Owners: 12/1/2007

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 Edwardsville # 0049031 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	15,857	11,877	5,293	33,027	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,857	11,877	5,293	33,027	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.20%

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 12/1/2007

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/1/2007 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 58 and days of care provided 3,362

Medicare Intermediary Novitas Solutions, Inc.

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Rosewood Care Center Of Edwardsville # 0049031 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	25,517	4,003	367,846	397,366		397,366	463	397,829			1
2	Food Purchase		209,075		209,075		209,075	(2,419)	206,656			2
3	Housekeeping		17,513	171,366	188,879		188,879		188,879			3
4	Laundry			114,244	114,244		114,244		114,244			4
5	Heat and Other Utilities			137,389	137,389		137,389	(8,577)	128,812			5
6	Maintenance	50,507	4,709	249,602	304,818		304,818	(42,272)	262,546			6
7	Other (specify):*							5,591	5,591			7
8	**TOTAL General Services**	76,024	235,300	1,040,447	1,351,771		1,351,771	(47,213)	1,304,558			8
	B. Health Care and Programs											
9	Medical Director			21,600	21,600		21,600		21,600			9
10	Nursing and Medical Records	2,216,205	216,616	139,635	2,572,456		2,572,456	29,305	2,601,761			10
10a	Therapy	66,895	2,703		69,598		69,598		69,598			10a
11	Activities	50,297	3,910	3,000	57,207		57,207		57,207			11
12	Social Services	60,003	14	3,000	63,017		63,017		63,017			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							2,882	2,882			15
16	**TOTAL Health Care and Programs**	2,393,400	223,243	167,235	2,783,878		2,783,878	32,187	2,816,065			16
	C. General Administration											
17	Administrative	97,026		334,496	431,522		431,522	(281,848)	149,674			17
18	Directors Fees											18
19	Professional Services			144,531	144,531		144,531	(47,978)	96,553			19
20	Dues, Fees, Subscriptions & Promotions			16,825	16,825		16,825	(1,218)	15,607			20
21	Clerical & General Office Expenses	86,430	23,914	535,828	646,172		646,172	(343,651)	302,521			21
22	Employee Benefits & Payroll Taxes			427,532	427,532		427,532		427,532			22
23	Inservice Training & Education											23
24	Travel and Seminar			887	887		887	996	1,883			24
25	Other Admin. Staff Transportation			14,135	14,135		14,135	(2,715)	11,420			25
26	Insurance-Prop.Liab.Malpractice			62,859	62,859		62,859	14,547	77,406			26
27	Other (specify):*							23,541	23,541			27
28	**TOTAL General Administration**	183,456	23,914	1,537,093	1,744,463		1,744,463	(638,325)	1,106,138			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,652,880	482,457	2,744,775	5,880,112		5,880,112	(653,351)	5,226,761			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 Edwardsville #0049031 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			11,147	11,147		11,147	80,707	91,854			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			185,227	185,227		185,227	623,841	809,068			32
33	Real Estate Taxes							85,219	85,219			33
34	Rent-Facility & Grounds			1,107,544	1,107,544		1,107,544	(1,090,455)	17,089			34
35	Rent-Equipment & Vehicles							28	28			35
36	Other (specify):*			23,101	23,101		23,101	32,403	55,504			36
37	**TOTAL Ownership**			1,327,019	1,327,019		1,327,019	(268,257)	1,058,762			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		257,221	756,479	1,013,700		1,013,700		1,013,700			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			249,595	249,595		249,595		249,595			42
43	Other (specify):*	92,364		3,939	96,303		96,303	(96,303)	(0)			43
44	**TOTAL Special Cost Centers**	92,364	257,221	1,010,013	1,359,598		1,359,598	(96,303)	1,263,295			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,745,244	739,678	5,081,807	8,566,729		8,566,729	(1,017,911)	7,548,818			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 Edwardsville # 0049031 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	(1,667)	02		4
5	Telephone, TV & Radio in Resident Rooms	(9,006)	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	(87,332)	30		9
10	Interest and Other Investment Income	(684)	32		10
11	Discounts, Allowances, Rebates & Refunds	(6,724)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(752)	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				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	(477,843)	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	(636)	20		28
29	Other-Attach Schedule	(205,747)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (790,391)		$	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)	(227,520)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (227,520)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,017,911)		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

STATE OF ILLINOIS

Rosewood Care Center Of Edwardsville

ID# 0049031

Report Period Beginning: 07/01/15

Ending: 06/30/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Salary	$ (88,764)	43	1
2	Marketing Services	(3,939)	43	2
3	Resident Reimbursement	(165)	10	3
4	Bank Charges	(2,925)	21	4
5	Miscellaneous Income	(7,202)	21	5
6	LOC Fees	(23,101)	36	6
7	Marketing Bonus	(3,600)	43	7
8	Building Co. - Audit Fees	(4,100)	19	8
9	Building Co. - Professional Fees	(883)	19	9
10	Building Co. - Bank Fees	(16,718)	21	10
11	Building Co. - Amortization Loan Fee	(5,204)	36	11
12	PAC Dues	(3,323)	20	12
13	Capitalized R&M	(2,696)	06	13
14	Marketing Travel	(13,513)	25	14
15	Non-Allowable Legal Fees	(15,247)	19	15
16	Vendor Late Charges	(14,368)	21	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**	(205,747)		49

Rosewood Care Center Of Edwardsville

ID# 0049031

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 Edwardsville # 0049031 **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				463								463	1
2	Food Purchase	(2,419)											(2,419)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(9,006)		158				271					(8,577)	5
6	Maintenance	(2,696)		96				(39,672)					(42,272)	6
7	Other (specify):*				49			5,542					5,591	7
8	**TOTAL General Services**	(14,121)		254	512			(33,858)					(47,213)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(165)			29,470								29,305	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				2,882								2,882	15
16	**TOTAL Health Care and Programs**	(165)			32,352								32,187	16
	C. General Administration													
17	Administrative			(196,496)	(92,471)	7,119							(281,848)	17
18	Directors Fees													18
19	Professional Services	(20,230)	6,247	115	83	18,948	(53,273)	132					(47,978)	19
20	Fees, Subscriptions & Promotions	(3,959)		2,327	2	243	44	126					(1,218)	20
21	Clerical & General Office Expenses	(525,780)	23,918	147,090	464	328	9,852	477					(343,651)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			477	169	293	57						996	24
25	Other Admin. Staff Transportation	(13,513)		2,417	3,055	1,480	606	3,241					(2,715)	25
26	Insurance-Prop.Liab.Malpractice		9,270	4,188				1,089					14,547	26
27	Other (specify):*			19,297	3,663		580						23,541	27
28	**TOTAL General Administration**	(563,481)	39,435	(20,584)	(85,035)	28,410	(42,134)	5,064					(638,325)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(577,767)	39,435	(20,330)	(52,171)	28,410	(42,134)	(28,794)					(653,351)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Center Of Edwardsville # 0049031 **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	(87,332)	151,017	15,808				1,214					80,707	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(684)	607,681	18,090		(1,245)							623,841	32
33	Real Estate Taxes		85,219										85,219	33
34	Rent-Facility & Grounds		(1,105,156)	14,701									(1,090,455)	34
35	Rent-Equipment & Vehicles				9	6		12					28	35
36	Other (specify):*	(28,305)	60,708										32,403	36
37	**TOTAL Ownership**	(116,321)	(200,531)	48,598	9	(1,239)		1,226					(268,257)	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):*	(96,303)											(96,303)	43
44	**TOTAL Special Cost Centers**	(96,303)											(96,303)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(790,391)	(161,096)	28,268	(52,161)	27,171	(42,134)	(27,568)					(1,017,911)	45

Facility Name & ID Number Rosewood Care Center Of Edwardsville # 0049031 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		

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	$ 1,105,156	Edwardsville Real Estate, LLC		$	$ (1,105,156)	1
2	V	32	Interest Income - Escrow	1,421	Edwardsville Real Estate, LLC			(1,421)	2
3	V	19	Audit Fees		Edwardsville Real Estate, LLC		4,100	4,100	3
4	V	19	Professional Fees		Edwardsville Real Estate, LLC		883	883	4
5	V	19	Professional Fees (Page 6D)		Edwardsville Real Estate, LLC		1,264	1,264	5
6	V	21	Bank Charges		Edwardsville Real Estate, LLC		16,718	16,718	6
7	V	32	Interest Expense - HUD Mortgage		Edwardsville Real Estate, LLC		609,102	609,102	7
8	V	36	Int Expense - HUD MIP		Edwardsville Real Estate, LLC		55,504	55,504	8
9	V	33	Real Estate Tax		Edwardsville Real Estate, LLC		85,219	85,219	9
10	V	30	Depreciation		Edwardsville Real Estate, LLC		151,017	151,017	10
11	V	36	Amortization Loan Fee		Edwardsville Real Estate, LLC		5,204	5,204	11
12	V	21	Base Admin Fee (Page 6A)		Edwardsville Real Estate, LLC		7,200	7,200	12
13	V	26	Insurance Expense - Property		Edwardsville Real Estate, LLC		9,270	9,270	13
14	Total			$ 1,106,577			$ 945,481	$ * (161,096)	14

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

Facility Name & ID Number Rosewood Care Center Of Edwardsville # 0049031 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%	$ 158	$ 158	15
16	V	6	MAINTENANCE EXPENSE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	96	96	16
17	V	19	PROFESSIONAL FEES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	115	115	17
18	V	20	DUES, SUBSCRIPTIONS, LICENSES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	2,327	2,327	18
19	V	21	OFFICE SALARIES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	121,501	121,501	19
20	V	21	OFFICE EXPENSES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	32,789	32,789	20
21	V	24	SEMINAR		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	477	477	21
22	V	25	TRAVEL EXPENSE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	2,417	2,417	22
23	V	26	INSURANCE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	4,188	4,188	23
24	V	27	EMPLOYEE BENEFITS		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	19,297	19,297	24
25	V	30	DEPRECIATION		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	15,808	15,808	25
26	V	32	INTEREST		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	18,090	18,090	26
27	V	34	BUILDING RENT		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	14,701	14,701	27
28	V								28
29	V	17	ADMINISTRATIVE FEE	196,496	MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%		(196,496)	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			$ 203,696			$ 231,964	$ * 28,268	39

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

Facility Name & ID Number Rosewood Care Center Of Edwardsville # 0049031 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%	$ 463	$ 463	15
16	V	7	DIETARY BENEFITS		BRAVO NURSING HOME SERVICES, INC.	100.00%	49	49	16
17	V	10	CORPORATE RN SALARIES		BRAVO NURSING HOME SERVICES, INC.	100.00%	29,470	29,470	17
18	V	15	CORPORATE RN SALARIES BENEFITS		BRAVO NURSING HOME SERVICES, INC.	100.00%	2,882	2,882	18
19	V	17	ADMINISTRATIVE SALARIES		BRAVO NURSING HOME SERVICES, INC.	100.00%	45,529	45,529	19
20	V	19	PROFESSIONAL FEES		BRAVO NURSING HOME SERVICES, INC.	100.00%	83	83	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%	464	464	22
23	V	24	SEMINAR & LODGING EXPENSE		BRAVO NURSING HOME SERVICES, INC.	100.00%	169	169	23
24	V	25	AUTO EXPENSE		BRAVO NURSING HOME SERVICES, INC.	100.00%	3,055	3,055	24
25	V	27	ADMINISTRATIVE & OFFICE BENEFITS		BRAVO NURSING HOME SERVICES, INC.	100.00%	3,663	3,663	25
26	V	35	AUTO LEASE		BRAVO NURSING HOME SERVICES, INC.	100.00%	9	9	26
27	V								27
28	V	17	ADMINISTRATVE 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			$ 85,839	$ * (52,161)	39

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

Facility Name & ID Number Rosewood Care Center Of Edwardsville # 0049031 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%	$ 7,119	$ 7,119	15
16	V	19	PROFESSIONAL FEES		BRAVO HOLDING COMPANY	100.00%	18,948	18,948	16
17	V	20	DUES & SUBSCRIPTIONS		BRAVO HOLDING COMPANY	100.00%	243	243	17
18	V	21	OFFICE EXPENSE		BRAVO HOLDING COMPANY	100.00%	328	328	18
19	V	24	SEMINAR EXPENSE		BRAVO HOLDING COMPANY	100.00%	293	293	19
20	V	25	AUTO & TRAVEL EXPENSE		BRAVO HOLDING COMPANY	100.00%	1,480	1,480	20
21	V	32	INTEREST		BRAVO HOLDING COMPANY	100.00%	(1,245)	(1,245)	21
22	V	35	AUTO RENTAL		BRAVO HOLDING COMPANY	100.00%	6	6	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			$			$ 27,171	$ * 27,171	39

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

Facility Name & ID Number Rosewood Care Center Of Edwardsville # 0049031 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%	$ 279	$ 279	15
16	V	20	LICENSES		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	44	44	16
17	V	21	OFFICE SALARIES		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	9,648	9,648	17
18	V	21	OFFICE EXPENSE		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	204	204	18
19	V	24	SEMINAR		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	57	57	19
20	V	25	AUTO / TRAVEL EXPENSE		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	606	606	20
21	V	27	EMPLOYEE BENEFITS		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	580	580	21
22	V								22
23	V	19	PROFESSIONAL FEES	52,288	CLAIMS ADMINISTRATION SERVICES, LLC	100.00%		(52,288)	23
24	V	19	PROFESSIONAL FEES (BLDG CO)	1,264	CLAIMS ADMINISTRATION SERVICES, LLC	100.00%		(1,264)	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			$ 53,552			$ 11,418	$ * (42,134)	39

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

Facility Name & ID Number Rosewood Care Center Of Edwardsville # 0049031 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%	$ 271	$ 271	15
16	V	6	MAINTENANCE SALARY		SENIOR LIVING SERVICES, INC.	100.00%	39,089	39,089	16
17	V	6	MAINTENANCE EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	3,967	3,967	17
18	V	7	MAINTENANCE BENEFITS		SENIOR LIVING SERVICES, INC.	100.00%	5,542	5,542	18
19	V	19	PROFESSIONAL FEES		SENIOR LIVING SERVICES, INC.	100.00%	132	132	19
20	V	20	LICENSES		SENIOR LIVING SERVICES, INC.	100.00%	126	126	20
21	V	21	OFFICE EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	477	477	21
22	V	25	AUTO / TRAVEL EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	3,241	3,241	22
23	V	26	INSURANCE		SENIOR LIVING SERVICES, INC.	100.00%	1,089	1,089	23
24	V	30	DEPRECIATION		SENIOR LIVING SERVICES, INC.	100.00%	1,214	1,214	24
25	V	35	AUTO LEASE		SENIOR LIVING SERVICES, INC.	100.00%	12	12	25
26	V	6	MAINTENANCE SUPPLIES		SENIOR LIVING SERVICES, INC.	100.00%	794	794	26
27	V								27
28	V	6	MAINTENANCE SERVICES	83,521	SENIOR LIVING SERVICES, INC.	100.00%		(83,521)	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			$ 83,521			$ 55,953	$ * (27,568)	39

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

Facility Name & ID Number Rosewood Care Center Of Edwardsville # 0049031 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 Edwardsville # 0049031 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 Edwardsville # 0049031 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 Edwardsville # 0049031 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 Edwardsville # 0049031 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	Edwardsville Real Estate, LLC	Edwardsville, IL	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 Elgin, Inc.	Elgin, IL	Bravo Holding Company, Inc.	St. Louis, MO	Holding Company	3
4			Bravo Care of Galesburg, Inc.	Galesburg, IL	Bravo Nursing Home Services, Inc.	St. Louis, MO	Management	4
5			Bravo Care of Inverness, Inc.	Inverness, IL	Bravo Team Health, Inc.	St. Louis, MO	Human Resources	5
6			Bravo Care of Joliet, Inc.	Joliet, 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 Edwardsville # 0049031 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 Edwardsville # 0049031 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	Hillel Yampol	Owner	Administrative	50.00%	See Attached	1.42	7.10%	Alloc. Salary	$ 1,615	17-7	1
2	Mark Yampol	CEO	Administrative	0	See Attached	1.42	7.10%	Alloc. Fees	7,119	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 8,734		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 Edwardsville # 0049031 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 Edwardsville # 0049031 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	$	33,027	$ 158	1
2	6	MAINTENANCE EXPENSE	PAT. DAYS	463,927	14	1,345		33,027	96	2
3	19	PROFESSIONAL FEES	PAT. DAYS	463,927	14	1,614		33,027	115	3
4	20	DUES, SUBSCRIPTIONS, LICEN	PAT. DAYS	463,927	14	32,685		33,027	2,327	4
5	21	OFFICE SALARIES	PAT. DAYS	463,927	14	1,706,712	1,706,712	33,027	121,501	5
6	21	OFFICE EXPENSES	PAT. DAYS	463,927	14	460,588		33,027	32,789	6
7	24	SEMINAR	PAT. DAYS	463,927	14	6,706		33,027	477	7
8	25	TRAVEL EXPENSE	PAT. DAYS	463,927	14	33,946		33,027	2,417	8
9	26	INSURANCE	PAT. DAYS	463,927	14	58,834		33,027	4,188	9
10	27	EMPLOYEE BENEFITS	PAT. DAYS	463,927	14	271,068		33,027	19,297	10
11	30	DEPRECIATION	PAT. DAYS	463,927	14	222,055		33,027	15,808	11
12	32	INTEREST	PAT. DAYS	463,927	14	254,102		33,027	18,090	12
13	34	BUILDING RENT	PAT. DAYS	463,927	14	206,500		33,027	14,701	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		$ 231,964	25

Facility Name & ID Number Rosewood Care Center Of Edwardsville # 0049031 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	33,027	$ 463	1
2	7	DIETARY BENEFITS	PAT. DAYS	463,927	14	687		33,027	49	2
3	10	CORPORATE RN SALARIES	PAT. DAYS	463,927	14	413,960	413,960	33,027	29,470	3
4	15	CORPORATE RN SALARIES BE	PAT. DAYS	463,927	14	40,484		33,027	2,882	4
5	17	ADMINISTRATIVE SALARIES	PAT. DAYS	463,927	14	639,544	639,544	33,027	45,529	5
6	19	PROFESSIONAL FEES	PAT. DAYS	463,927	14	1,170		33,027	83	6
7	20	DUES & SUBSCRIPTIONS	PAT. DAYS	463,927	14	27		33,027	2	7
8	21	OFFICE EXPENSES	PAT. DAYS	463,927	14	6,517		33,027	464	8
9	24	SEMINAR & LODGING EXPEN	PAT. DAYS	463,927	14	2,370		33,027	169	9
10	25	AUTO EXPENSE	PAT. DAYS	463,927	14	42,910		33,027	3,055	10
11	27	ADMINISTRATIVE & OFFICE I	PAT. DAYS	463,927	14	51,458		33,027	3,663	11
12	35	AUTO LEASE	PAT. DAYS	463,927	14	133		33,027	9	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		$ 85,838	25

Facility Name & ID Number Rosewood Care Center Of Edwardsville # 0049031 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	$	33,027	$ 7,119	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	463,927	14	266,160		33,027	18,948	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	463,927	14	3,410		33,027	243	3
4	21	OFFICE EXPENSE	PATIENT DAYS	463,927	14	4,609		33,027	328	4
5	24	SEMINAR EXPENSE	PATIENT DAYS	463,927	14	4,112		33,027	293	5
6	25	AUTO & TRAVEL EXPENSE	PATIENT DAYS	463,927	14	20,788		33,027	1,480	6
7	32	INTEREST	PATIENT DAYS	463,927	14	(17,495)		33,027	(1,245)	7
8	35	AUTO RENTAL	PATIENT DAYS	463,927	14	85		33,027	6	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	$		$ 27,172	25

Facility Name & ID Number Rosewood Care Center Of Edwardsville # 0049031 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	$	29,552	$ 279	1
2	20	LICENSES	ACTUAL FEES	667,999	13	1,000		29,552	44	2
3	21	OFFICE SALARIES	ACTUAL FEES	667,999	13	218,085	218,085	29,552	9,648	3
4	21	OFFICE EXPENSE	ACTUAL FEES	667,999	13	4,612		29,552	204	4
5	24	SEMINAR	ACTUAL FEES	667,999	13	1,281		29,552	57	5
6	25	AUTO / TRAVEL EXPENSE	ACTUAL FEES	667,999	13	13,694		29,552	606	6
7	27	EMPLOYEE BENEFITS	ACTUAL FEES	667,999	13	13,112		29,552	580	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		$ 11,418	25

Facility Name & ID Number Rosewood Care Center Of Edwardsville # 0049031 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	$	83,521	$ 271	1
2	6	MAINTENANCE SALARY	ACTUAL FEES	929,714	14	435,123	435,123	83,521	39,089	2
3	6	MAINTENANCE EXPENSE	ACTUAL FEES	929,714	14	44,153		83,521	3,967	3
4	7	MAINTENANCE BENEFITS	ACTUAL FEES	929,714	14	61,694		83,521	5,542	4
5	19	PROFESSIONAL FEES	ACTUAL FEES	929,714	14	1,467		83,521	132	5
6	20	LICENSES	ACTUAL FEES	929,714	14	1,402		83,521	126	6
7	21	OFFICE EXPENSE	ACTUAL FEES	929,714	14	5,306		83,521	477	7
8	25	AUTO / TRAVEL EXPENSE	ACTUAL FEES	929,714	14	36,073		83,521	3,241	8
9	26	INSURANCE	ACTUAL FEES	929,714	14	12,121		83,521	1,089	9
10	30	DEPRECIATION	ACTUAL FEES	929,714	14	13,517		83,521	1,214	10
11	35	AUTO LEASE	ACTUAL FEES	929,714	14	135		83,521	12	11
12	6	MAINTENANCE SUPPLIES	DIRECT ALLOCATION		13	6,541			794	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		$ 55,954	25

Facility Name & ID Number Rosewood Care Center Of Edwardsville # 0049031 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 Edwardsville # 0049031 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 Edwardsville # 0049031 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 Edwardsville # 0049031 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 Edwardsville # 0049031 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**		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	Berkadia		X	Mortgage	86175.55	7/1/04	$ 4,943,300	$ 11,206,579	8/1/39	0.0544	$ 609,102	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Mid Cap		X	Revolving Line of Credit							90,048	6
7	Bravo Holding		X	Note Payable				2,021,828			95,178	7
8	See Supplemental Schedule										(1,245)	8
9	TOTAL Facility Related				86175.55		$ 4,943,300	$ 13,228,408			$ 793,083	9
	B. Non-Facility Related*											
10	Interest Inc		X								(684)	10
11	Interest Inc - Building Co		X								(1,421)	11
12	Alloc. From Midwest Admin. Serv		X								18,090	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 15,985	14
15	TOTALS (line 9+line14)						$ 4,943,300	$ 13,228,408			$ 809,068	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 55,504 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 Edwardsville # 0049031 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	Alloc from Bravo Holding		X				$	$			$ (1,245)	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										(1,245)	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 Edwardsville # 0049031 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.**	$ 105,270	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.)		$ 84,137	2
3. Under or (over) accrual (line 2 minus line 1).		$ (21,133)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 106,352	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 85,219	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	81,938	8
	2012	82,454	9
	2013	83,653	10
	2014	83,548	11
	2015	85,905	12

Accrual based on prior year tax bill

Line 2 includes 3 of 4 payments towards the 2014 tax bill, and 1 of 4 payments towards the 2015 tax bill.

	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 Edwardsville COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0049031

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.	14-1-15-22-00-000-002.004	Long Term Care Property	$ 85,905.28	$ 85,905.28
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 85,905.28	$ 85,905.28

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 Edwardsville COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0049031

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 Edwardsville # 0049031 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:
3. Current Period Amortization:
4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Rosewood Care Center Of Edwardsville # 0049031 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		2013	1995	$ 2,452,281	$ 151,017	40	$ 61,307	$ (89,710)	$ 153,268	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 Edwardsville # 0049031 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)		21,271			934	934	1,674	67
68	Related Party Allocations (Pages 12H & 12I)								68
69	Financial Statement Depreciation			11,148			(11,148)		69
70	TOTAL (lines 4 thru 69)		$ 2,473,552	$ 162,165		$ 62,241	$ (99,924)	$ 154,942	70

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

Facility Name & ID Number Rosewood Care Center Of Edwardsville # 0049031 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		$ 2,473,552	$ 162,165		$ 62,241	$ (99,924)	$ 154,942	1
2	Wall Covering/Cove Base-Hall, 2 Dining Rooms	2013	4,380		20	626	626	1,773	2
3	Repaired Fire Sprinkler System	2016	2,696		20	135	135	135	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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,480,628	$ 162,165		$ 63,002	$ (99,163)	$ 156,850	34

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

Facility Name & ID Number Rosewood Care Center Of Edwardsville # 0049031 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		$ 2,480,628	$ 162,165		$ 63,002	$ (99,163)	$ 156,850	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
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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)		$ 2,480,628	$ 162,165		$ 63,002	$ (99,163)	$ 156,850	34

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

Facility Name & ID Number Rosewood Care Center Of Edwardsville # 0049031 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		$ 2,480,628	$ 162,165		$ 63,002	$ (99,163)	$ 156,850	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
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19									19
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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)		$ 2,480,628	$ 162,165		$ 63,002	$ (99,163)	$ 156,850	34

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

Facility Name & ID Number Rosewood Care Center Of Edwardsville # 0049031 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		$ 2,480,628	$ 162,165		$ 63,002	$ (99,163)	$ 156,850	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
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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)		$ 2,480,628	$ 162,165		$ 63,002	$ (99,163)	$ 156,850	34

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

Facility Name & ID Number Rosewood Care Center Of Edwardsville # 0049031 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	HVAC Improvements	2014	2,560		10	256	256	533	9
10	Replaced Hot Water Heater	2014	2,806		10	281	281	445	10
11	Sprinkler Repairs - Repair Leaks, Replace Pipes	2014	15,905		40	398	398	696	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)		$ 21,271	$		$ 934	$ 934	$ 1,674	34

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

Facility Name & ID Number Rosewood Care Center Of Edwardsville # 0049031 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		$ 21,271	$		$ 934	$ 934	$ 1,674	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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21									21
22									22
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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)		$ 21,271	$		$ 934	$ 934	$ 1,674	34

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

Facility Name & ID Number Rosewood Care Center Of Edwardsville # 0049031 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
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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 Edwardsville # 0049031 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
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)		$	$		$	$	$	34

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

Facility Name & ID Number Rosewood Care Center Of Edwardsville # 0049031 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	$ 72,839	$ 2,874	$ 13,960	$ 11,086	10	$ 40,370	71
72	Current Year Purchases	15,724		745	745	10	745	72
73	Fully Depreciated Assets	16,554	122	122		10	16,554	73
74								74
75	TOTALS	$ 105,117	$ 2,996	$ 14,827	$ 11,831		$ 57,669	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		Allocated from Midwest Admin. S	various	$ 50,254	$ 12,812	$ 12,812	$	5	$ 32,662	76
77		Allocated from Senior Living Ser	various	13,446	1,214	1,214		5	12,582	77
78										78
79										79
80	TOTALS			$ 63,700	$ 14,026	$ 14,026	$		$ 45,244	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,050,516	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 179,187	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 91,855	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (87,332)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 259,763	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 Edwardsville # 0049031 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	Of-Site Storage				2,388			5
6	Alloc. From Midwest Admin. Services				14,701			6
7	TOTAL				$ 17,089 **			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	Alloc. From Bravo NH Services		$	$ 9	17
18	Alloc. From Bravo Holding Company			6	18
19	Alloc. From Senior Living Services			13	19
20					20
21	TOTAL		$	$ 28	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 Edwardsville # 0049031 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 Edwardsville # 0049031 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 Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 315,483	$		$ 315,483	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			91,197			91,197	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			344,053			344,053	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				225,257		225,257	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					5,746	31,964		37,710	13
14	TOTAL			$		$ 756,479	$ 257,221		$ 1,013,700	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 Edwardsville **#** 0049031 **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	$ 1,017	$ 2,356	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,693,964	1,693,964	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	43,729	47,205	6
7	Other Prepaid Expenses	4,410	239,848	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	2,467	2,467	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,745,587	$ 1,985,840	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		401,071	13
14	Buildings, at Historical Cost		351,731	14
15	Leasehold Improvements, at Historical Cost	4,380	4,169,945	15
16	Equipment, at Historical Cost	52,604	506,809	16
17	Accumulated Depreciation (book methods)	(34,076)	(2,802,299)	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):		95,764	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 22,908	$ 2,723,021	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,768,495	$ 4,708,861	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,033,741	$ 2,114,259	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,021,828	2,021,828	29
30	Accrued Salaries Payable	88,741	88,741	30
31	Accrued Taxes Payable (excluding real estate taxes)	125,584	125,584	31
32	Accrued Real Estate Taxes(Sch.IX-B)		106,352	32
33	Accrued Interest Payable		683,346	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	5,016	5,016	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	1,593,525	290,230	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,868,435	$ 5,435,356	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,206,579	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)**	$	$ 11,206,579	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,868,435	$ 16,641,935	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (4,099,940)	$ (11,933,074)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,768,495	$ 4,708,861	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,689,542)	1
2	Restatements (describe):		2
3	**Prior year post closing adjustments**	(14,089)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,703,631)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,396,309)	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)**	$ (1,396,309)	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)**	$ (4,099,940)	24 *

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

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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	$ 6,726,224	1
2	Discounts and Allowances for all Levels	(1,688,597)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,037,627	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,787,295	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,787,295	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	900	13
14	Non-Patient Meals	1,667	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	253,332	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	26,735	19
20	Radiology and X-Ray	9,663	20
21	Other Medical Services	38,591	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 330,888	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	684	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 684	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	13,926	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 13,926	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,170,420	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,351,771	31
32	Health Care	2,783,878	32
33	General Administration	1,744,463	33
	B. Capital Expense		
34	Ownership	1,327,019	34
	C. Ancillary Expense		
35	Special Cost Centers	1,110,003	35
36	Provider Participation Fee	249,595	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,566,729	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,396,309)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,396,309)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,213,543	44
45	Private Pay - Net Inpatient Revenue	2,195,637	45
46	Medicare - Net Inpatient Revenue	515,991	46
47	Other-(specify) Insurance/Managed Care	112,456	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,037,627	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	2,358	2,708	$ 83,304	$ 30.76	1
2	Assistant Director of Nursing	2,122	2,288	61,569	26.91	2
3	Registered Nurses	26,427	28,518	726,592	25.48	3
4	Licensed Practical Nurses	20,093	21,732	410,912	18.91	4
5	CNAs & Orderlies	76,814	81,522	891,500	10.94	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,670	3,953	66,895	16.92	8
9	Activity Director	1,781	1,833	24,827	13.54	9
10	Activity Assistants	2,754	2,899	25,470	8.79	10
11	Social Service Workers	4,095	4,285	60,003	14.00	11
12	Dietician					12
13	Food Service Supervisor	316	324	6,188	19.10	13
14	Head Cook					14
15	Cook Helpers/Assistants	1,790	2,117	19,329	9.13	15
16	Dishwashers					16
17	Maintenance Workers	2,378	2,576	50,507	19.61	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,176	2,420	97,026	40.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,656	9,158	86,430	9.44	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	3,968	4,363	42,328	9.70	31
32	Other Health Care(specify)					32
33	Other(specify)	4,161	4,550	92,364	20.30	33
34	TOTAL (lines 1 - 33)	163,559	175,246	$ 2,745,244 *	$ 15.67	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	$ 564	01-03	35
36	Medical Director	Monthly	21,600	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,255	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	3,000	11-03	44
45	Social Service Consultant	Monthly	3,000	12-03	45
46	Other(specify)				46
47	Outsorced Dietary	Monthly	367,282	01-03	47
48					48
49	TOTAL (lines 35 - 48)		$ 403,701		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	185	$ 8,804	10-03	50
51	Licensed Practical Nurses	1,251	43,143	10-03	51
52	Certified Nurse Assistants/Aides	3,611	79,433	10-03	52
53	TOTAL (lines 50 - 52)	5,046	$ 131,380		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sara McMahan	Administrator	0	$ 97,026
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 97,026

B. Administrative - Other

Description	Amount
Bravo Nursing Home Services - Management Fee	$ 138,000
Midwest Admin Services - Base Admin Fee	36,000
Midwest Admin Services -Volume Admin Fee	160,496
TOTAL (agree to Schedule V, line 17, col. 3)	$ 334,496
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Templin Healthcare Acct Serv	Accounting	$ 1,856
Claims Administrative Services	Claims Management	52,288
Infinite Solutions Support Charges	IT Support	20,943
WestLaw	Computer Consulting	846
See Attached	Legal Fees	27,304
Intelligencer	Notice of Non-Discrimination	56
County Clerk	Court Costs	448
Marcum LLP	Accounting	1,466
Odessa Healthcare	Operation Consultant	39,323
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 144,531

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 73,601
Unemployment Compensation Insurance	46,300
FICA Taxes	204,208
Employee Health Insurance	82,817
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals & Vaccinations	6,801
Dental Insurance	3,818
Employee Relations	3,490
401K Expense	6,498
TOTAL (agree to Schedule V, line 22, col.8)	$ 427,532

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	635
Health Care Worker Background Check	
(Indicate # of checks performed 216.7)	2,818
Patient Background Checks	
Dues & Subscriptions	5,058
Licenses	375
Alloc. from Midwest Amin. Services	2,327
Alloc. from Bravo Nursing Home Services	2
See Supplemental Schedule	413
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,607

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	887
Alloc. from Midwest Amin. Services	477
Alloc. from Bravo Nursing Home Services	169
See Supplemental Schedule	350
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,883

* Attach copy of IMRF notifications

**See instructions.

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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 - $8,820**

(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 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **64,833** 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. $ **249,595**
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. $ **1,667**

(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