		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: 0049346

Facility Name: Rosewood Care Center Of Elgin

Address: 2355 Royal Boulevard (Number) Elgin (City) 60123 (Zip Code)

County: Kane

Telephone Number: (847) 888-9585 **Fax #** (847) 888-4173

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:** (**Email Address:** [redacted]

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 Elgin # 0049346 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	139	Skilled (SNF)	139	50,874	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	139	TOTALS	139	50,874	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	16,168	13,537	9,129	38,834	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,168	13,537	9,129	38,834	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.33%

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 12/01/2007

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/01/2007 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 67 and days of care provided 6,916

Medicare Intermediary Novitas Solutions, Inc.

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Rosewood Care Center Of Elgin # 0049346 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	33,321	3,710	443,656	480,687		480,687	544	481,231			1
2	Food Purchase		262,323		262,323		262,323	(12,503)	249,820			2
3	Housekeeping		22,389	193,125	215,514		215,514		215,514			3
4	Laundry			128,750	128,750		128,750		128,750			4
5	Heat and Other Utilities			187,841	187,841		187,841	(11,746)	176,095			5
6	Maintenance	34,587	5,916	271,335	311,838		311,838	(54,947)	256,891			6
7	Other (specify):*							5,877	5,877			7
8	**TOTAL General Services**	67,908	294,338	1,224,707	1,586,953		1,586,953	(72,775)	1,514,178			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	3,134,277	316,186	210,624	3,661,087		3,661,087	34,651	3,695,738			10
10a	Therapy	186,476	1,990		188,466		188,466		188,466			10a
11	Activities	65,339	3,711	2,676	71,726		71,726		71,726			11
12	Social Services	106,306		2,200	108,506		108,506		108,506			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							3,389	3,389			15
16	**TOTAL Health Care and Programs**	3,492,398	321,887	227,500	4,041,785		4,041,785	38,040	4,079,825			16
	C. General Administration											
17	Administrative	110,512		431,945	542,457		542,457	(370,040)	172,417			17
18	Directors Fees											18
19	Professional Services			84,299	84,299		84,299	73,710	158,009			19
20	Dues, Fees, Subscriptions & Promotions			23,822	23,822		23,822	(530)	23,292			20
21	Clerical & General Office Expenses	141,687	33,479	547,362	722,528		722,528	(307,628)	414,900			21
22	Employee Benefits & Payroll Taxes			534,050	534,050		534,050		534,050			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,471	1,471		1,471	1,176	2,647			24
25	Other Admin. Staff Transportation			1,063	1,063		1,063	12,348	13,411			25
26	Insurance-Prop.Liab.Malpractice			72,812	72,812		72,812	16,138	88,950			26
27	Other (specify):*							27,737	27,737			27
28	**TOTAL General Administration**	252,199	33,479	1,696,824	1,982,502		1,982,502	(547,088)	1,435,414			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,812,505	649,704	3,149,031	7,611,240		7,611,240	(581,823)	7,029,417			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 Elgin #0049346 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	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			14,426	14,426		14,426	98,657	113,083			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			82,944	82,944		82,944	48,632	131,576			32
33	Real Estate Taxes							123,739	123,739			33
34	Rent-Facility & Grounds			904,795	904,795		904,795	(885,160)	19,635			34
35	Rent-Equipment & Vehicles			195	195		195	31	226			35
36	Other (specify):*			16,903	16,903		16,903	51,397	68,300			36
37	**TOTAL Ownership**			1,019,263	1,019,263		1,019,263	(562,705)	456,558			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		418,096	883,111	1,301,207		1,301,207		1,301,207			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			269,276	269,276		269,276		269,276			42
43	Other (specify):*	87,876		1,422	89,298		89,298	(89,297)	1			43
44	**TOTAL Special Cost Centers**	87,876	418,096	1,153,809	1,659,781		1,659,781	(89,297)	1,570,484			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,900,381	1,067,800	5,322,103	10,290,284		10,290,284	(1,233,826)	9,056,458			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 Elgin # 0049346 Report Period Beginning: 07/01/15 Ending: 06/30/16

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,134)	02		4
5	Telephone, TV & Radio in Resident Rooms	(12,217)	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	(125,614)	30		9
10	Interest and Other Investment Income	(298,678)	32		10
11	Discounts, Allowances, Rebates & Refunds	(7,606)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(925)	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	(477,827)	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	(656)	20		28
29	Other-Attach Schedule	(180,290)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,106,947)		$	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)	(126,879)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (126,879)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,233,826)		37

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

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

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

Rosewood Care Center Of Elgin

ID# 0049346

Report Period Beginning: 07/01/15

Ending: 06/30/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Salary	$ (44,689)	43	1
2	Team Health - Marketing	(40,937)	43	2
3	Marketing	(688)	43	3
4	Bank Charges	(3,790)	21	4
5	Vending Income	(838)	02	5
6	MidCap Line of Credit Fees	(16,903)	36	6
7	Marketing Bonus	(1,550)	43	7
8	Team Health - Marketing Bonus	(700)	43	8
9	Vendor Late Charges	(21,422)	21	9
10	PAC Dues	(3,086)	20	10
11	Capitalized R&M	(13,690)	06	11
12	Bldg Co - Professional Fees	(5,113)	19	12
13	Bldg Co - Loan Fee	(6,089)	36	13
14	Marketing Travel	(733)	43	14
15	Bldg Co - Bank Charges	(12,255)	21	15
16	Non Allowable Legal Fees	(7,807)	19	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(180,290)		49

Rosewood Care Center Of Elgin

ID# 0049346

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 Elgin # 0049346 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				544								544	1
2	Food Purchase	(12,503)											(12,503)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(12,217)		186				285					(11,746)	5
6	Maintenance	(13,690)		113				(41,370)					(54,947)	6
7	Other (specify):*				57			5,819					5,877	7
8	TOTAL General Services	(38,409)		299	602			(35,267)					(72,775)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				34,651								34,651	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				3,389								3,389	15
16	TOTAL Health Care and Programs				38,040								38,040	16
	C. General Administration													
17	Administrative			(293,945)	(84,466)	8,371							(370,040)	17
18	Directors Fees													18
19	Professional Services	(12,920)	5,113	135	98	22,279	58,867	138					73,710	19
20	Fees, Subscriptions & Promotions	(3,742)		2,736	2	285	56	132					(530)	20
21	Clerical & General Office Expenses	(515,294)	19,455	174,218	546	386	12,560	500					(307,628)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			561	198	344	72						1,176	24
25	Other Admin. Staff Transportation			2,842	3,592	1,740	772	3,402					12,348	25
26	Insurance-Prop.Liab.Malpractice		10,070	4,925				1,143					16,138	26
27	Other (specify):*			22,690	4,307		739						27,737	27
28	TOTAL General Administration	(531,956)	34,638	(85,837)	(75,722)	33,406	73,067	5,317					(547,088)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(570,366)	34,638	(85,539)	(37,080)	33,406	73,067	(29,950)					(581,823)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Center Of Elgin # 0049346 **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	(125,614)	204,408	18,588				1,275					98,657	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(298,678)	327,504	21,270		(1,464)							48,632	32
33	Real Estate Taxes		123,739										123,739	33
34	Rent-Facility & Grounds		(902,446)	17,286									(885,160)	34
35	Rent-Equipment & Vehicles				11	7		13					31	35
36	Other (specify):*	(22,992)	74,389										51,397	36
37	TOTAL Ownership	(447,284)	(172,406)	57,143	11	(1,457)		1,288					(562,705)	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):*	(89,297)											(89,297)	43
44	TOTAL Special Cost Centers	(89,297)											(89,297)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,106,947)	(137,768)	(28,395)	(37,069)	31,948	73,067	(28,662)					(1,233,826)	45

Facility Name & ID Number Rosewood Care Center Of Elgin # 0049346 Report Period Beginning: 07/01/15 Ending: 06/30/16

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6 - Supplemental		See Page 6 - Supplemental		See Page 6 - Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ 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	$ 902,446	Elgin Real Estate, LLC		$	$ (902,446)	1
2	V	32	Interest Income - Escrow	125	Elgin Real Estate, LLC			(125)	2
3	V	19	Audit Fees - HB&Co.		Elgin Real Estate, LLC		4,100	4,100	3
4	V	19	Professional Fees		Elgin Real Estate, LLC		1,013	1,013	4
5	V	21	Bank Charges		Elgin Real Estate, LLC		12,255	12,255	5
6	V	32	Interest Expense - HUD Mortgage		Elgin Real Estate, LLC		327,629	327,629	6
7	V	36	Interest Expense - HUD MIP		Elgin Real Estate, LLC		68,300	68,300	7
8	V	33	Real Estate Taxes		Elgin Real Estate, LLC		123,739	123,739	8
9	V	30	Depreciation		Elgin Real Estate, LLC		204,408	204,408	9
10	V	36	Amortization Loan Fee		Elgin Real Estate, LLC		6,089	6,089	10
11	V	21	Base Admin Fee (P. 6A)		Elgin Real Estate, LLC		7,200	7,200	11
12	V	26	Insurance Expense - Property		Elgin Real Estate, LLC		10,070	10,070	12
13	V								13
14	Total			$ 902,571			$ 764,803	$ * (137,768)	14

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

Facility Name & ID Number Rosewood Care Center Of Elgin # 0049346 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		2	3	4	5	6	7	8	
	Schedule V		Line	Cost Per General Ledger Item	Amount	Cost to Related Organization Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		5	UTILITIES	$	MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	$ 186	$ 186	15
16	V		6	MAINTENANCE EXPENSE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	113	113	16
17	V		19	PROFESSIONAL FEES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	135	135	17
18	V		20	DUES, SUBSCRIPTIONS, LICENSES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	2,736	2,736	18
19	V		21	OFFICE SALARIES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	142,864	142,864	19
20	V		21	OFFICE EXPENSES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	38,555	38,555	20
21	V		24	SEMINAR		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	561	561	21
22	V		25	TRAVEL EXPENSE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	2,842	2,842	22
23	V		26	INSURANCE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	4,925	4,925	23
24	V		27	EMPLOYEE BENEFITS		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	22,690	22,690	24
25	V		30	DEPRECIATION		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	18,588	18,588	25
26	V		32	INTEREST		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	21,270	21,270	26
27	V		34	BUILDING RENT		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	17,286	17,286	27
28	V									28
29	V		17	ADMINISTRATIVE FEE	293,945	MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%		(293,945)	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				$ 301,145			$ 272,750	$ * (28,395)	39

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

Facility Name & ID Number Rosewood Care Center Of Elgin # 0049346 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%	$ 544	$ 544	15
16	V	7	DIETARY BENEFITS		BRAVO NURSING HOME SERVICES, INC.	100.00%	57	57	16
17	V	10	CORPORATE RN SALARIES		BRAVO NURSING HOME SERVICES, INC.	100.00%	34,651	34,651	17
18	V	15	CORPORATE RN SALARIES BENEFITS		BRAVO NURSING HOME SERVICES, INC.	100.00%	3,389	3,389	18
19	V	17	ADMINISTRATIVE SALARIES		BRAVO NURSING HOME SERVICES, INC.	100.00%	53,534	53,534	19
20	V	19	PROFESSIONAL FEES		BRAVO NURSING HOME SERVICES, INC.	100.00%	98	98	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%	546	546	22
23	V	24	SEMINAR & LODGING EXPENSE		BRAVO NURSING HOME SERVICES, INC.	100.00%	198	198	23
24	V	25	AUTO EXPENSE		BRAVO NURSING HOME SERVICES, INC.	100.00%	3,592	3,592	24
25	V	27	ADMINISTRATIVE & OFFICE BENEFITS		BRAVO NURSING HOME SERVICES, INC.	100.00%	4,307	4,307	25
26	V	35	AUTO LEASE		BRAVO NURSING HOME SERVICES, INC.	100.00%	11	11	26
27	V								27
28	V	17	ADMINISTRATIVE FEE	138,000	BRAVO NURSING HOME SERVICES, INC.	100.00%		(138,000)	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 138,000			$ 100,931	$ * (37,069)	39

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

Facility Name & ID Number Rosewood Care Center Of Elgin # 0049346 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%	$ 8,371	$ 8,371	15
16	V	19	PROFESSIONAL FEES		BRAVO HOLDING COMPANY	100.00%	22,279	22,279	16
17	V	20	DUES & SUBSCRIPTIONS		BRAVO HOLDING COMPANY	100.00%	285	285	17
18	V	21	OFFICE EXPENSE		BRAVO HOLDING COMPANY	100.00%	386	386	18
19	V	24	SEMINAR EXPENSE		BRAVO HOLDING COMPANY	100.00%	344	344	19
20	V	25	AUTO & TRAVEL EXPENSE		BRAVO HOLDING COMPANY	100.00%	1,740	1,740	20
21	V	32	INTEREST		BRAVO HOLDING COMPANY	100.00%	(1,464)	(1,464)	21
22	V	35	AUTO RENTAL		BRAVO HOLDING COMPANY	100.00%	7	7	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			$			$ 31,948	$ * 31,948	39

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

Facility Name & ID Number Rosewood Care Center Of Elgin # 0049346 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		2	3	4	5	6	7	8	
	Schedule V		Line	Cost Per General Ledger Item	Amount	Cost to Related Organization Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		19	PROFESSIONAL FEES	$	CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	$ 356	$ 356	15
16	V		20	LICENSES		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	56	56	16
17	V		21	OFFICE SALARIES		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	12,300	12,300	17
18	V		21	OFFICE EXPENSE		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	260	260	18
19	V		24	SEMINAR		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	72	72	19
20	V		25	AUTO / TRAVEL EXPENSE		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	772	772	20
21	V		27	EMPLOYEE BENEFITS		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	739	739	21
22	V									22
23	V		19	PROFESSIONAL FEES	(58,511)	CLAIMS ADMINISTRATION SERVICES, LLC	100.00%		58,511	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				$ (58,511)			$ 14,556	$ * 73,067	39

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

Facility Name & ID Number Rosewood Care Center Of Elgin # 0049346 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		2	3	4	5	6	7	8	
	Schedule V		Line	Cost Per General Ledger Item	Amount	Cost to Related Organization Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		5	UTILITIES	$	SENIOR LIVING SERVICES, INC.	100.00%	$ 285	$ 285	15
16	V		6	MAINTENANCE SALARY		SENIOR LIVING SERVICES, INC.	100.00%	41,041	41,041	16
17	V		6	MAINTENANCE EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	4,165	4,165	17
18	V		7	MAINTENANCE BENEFITS		SENIOR LIVING SERVICES, INC.	100.00%	5,819	5,819	18
19	V		19	PROFESSIONAL FEES		SENIOR LIVING SERVICES, INC.	100.00%	138	138	19
20	V		20	LICENSES		SENIOR LIVING SERVICES, INC.	100.00%	132	132	20
21	V		21	OFFICE EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	500	500	21
22	V		25	AUTO / TRAVEL EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	3,402	3,402	22
23	V		26	INSURANCE		SENIOR LIVING SERVICES, INC.	100.00%	1,143	1,143	23
24	V		30	DEPRECIATION		SENIOR LIVING SERVICES, INC.	100.00%	1,275	1,275	24
25	V		35	AUTO LEASE		SENIOR LIVING SERVICES, INC.	100.00%	13	13	25
26	V		6	MAINTENANCE SUPPLIES		SENIOR LIVING SERVICES, INC.	100.00%	1,115	1,115	26
27	V									27
28	V		6	MAINTENANCE SERVICES	87,691	SENIOR LIVING SERVICES, INC.	100.00%		(87,691)	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				$ 87,691			$ 59,029	$ * (28,662)	39

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

Facility Name & ID Number Rosewood Care Center Of Elgin # 0049346 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 Elgin # 0049346 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 Elgin # 0049346 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 Elgin # 0049346 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 Elgin # 0049346 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 East Alton, Inc.	Alton, IL	Northbrook Real Estate, LLC		Lessor	1
2	Hillel Yampol	50.00%	Bravo Care of East Peoria, Inc.	East Peoria, IL	Bravo Administrative Services, Inc.	St. Louis, MO	Administration	2
3			Bravo Care of Edwardsville, Inc.	Edwardsville, IL	Bravo Holding Company, Inc.	St. Louis, MO	Holding Company	3
4			Bravo Care of 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 Elgin # 0049346 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 Elgin # 0049346 Report Period Beginning: 07/01/15 Ending: 06/30/16

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Yampol	CEO	Administrative		See Attached	1.67	8.35%	Alloc. Fees	$ 8,371	17-07	1
2	Hillel Yampol	Owner	Administrative	50.00%	See Attached	1.67	8.35%	Alloc. Salary	1,899	17-07	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 10,270		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 Elgin # 0049346 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 Elgin # 0049346 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	$	38,834	$ 186	1
2	6	MAINTENANCE EXPENSE	PAT. DAYS	463,927	14	1,345		38,834	113	2
3	19	PROFESSIONAL FEES	PAT. DAYS	463,927	14	1,614		38,834	135	3
4	20	DUES, SUBSCRIPTIONS, LICEI	PAT. DAYS	463,927	14	32,685		38,834	2,736	4
5	21	OFFICE SALARIES	PAT. DAYS	463,927	14	1,706,712	1,706,712	38,834	142,864	5
6	21	OFFICE EXPENSES	PAT. DAYS	463,927	14	460,588		38,834	38,555	6
7	24	SEMINAR	PAT. DAYS	463,927	14	6,706		38,834	561	7
8	25	TRAVEL EXPENSE	PAT. DAYS	463,927	14	33,946		38,834	2,842	8
9	26	INSURANCE	PAT. DAYS	463,927	14	58,834		38,834	4,925	9
10	27	EMPLOYEE BENEFITS	PAT. DAYS	463,927	14	271,068		38,834	22,690	10
11	30	DEPRECIATION	PAT. DAYS	463,927	14	222,055		38,834	18,588	11
12	32	INTEREST	PAT. DAYS	463,927	14	254,102		38,834	21,270	12
13	34	BUILDING RENT	PAT. DAYS	463,927	14	206,500		38,834	17,286	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		$ 272,751	25

Facility Name & ID Number Rosewood Care Center Of Elgin # 0049346 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	38,834	$ 544	1
2	7	DIETARY BENEFITS	PAT. DAYS	463,927	14	687		38,834	57	2
3	10	CORPORATE RN SALARIES	PAT. DAYS	463,927	14	413,960	413,960	38,834	34,651	3
4	15	CORPORATE RN SALARIES B	PAT. DAYS	463,927	14	40,484		38,834	3,389	4
5	17	ADMINISTRATIVE SALARIES	PAT. DAYS	463,927	14	639,544	639,544	38,834	53,534	5
6	19	PROFESSIONAL FEES	PAT. DAYS	463,927	14	1,170		38,834	98	6
7	20	DUES & SUBSCRIPTIONS	PAT. DAYS	463,927	14	27		38,834	2	7
8	21	OFFICE EXPENSES	PAT. DAYS	463,927	14	6,517		38,834	546	8
9	24	SEMINAR & LODGING EXPEN	PAT. DAYS	463,927	14	2,370		38,834	198	9
10	25	AUTO EXPENSE	PAT. DAYS	463,927	14	42,910		38,834	3,592	10
11	27	ADMINISTRATIVE & OFFICE	PAT. DAYS	463,927	14	51,458		38,834	4,307	11
12	35	AUTO LEASE	PAT. DAYS	463,927	14	133		38,834	11	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		$ 100,929	25

Facility Name & ID Number Rosewood Care Center Of Elgin # 0049346 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	$	38,834	$ 8,371	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	463,927	14	266,160		38,834	22,279	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	463,927	14	3,410		38,834	285	3
4	21	OFFICE EXPENSE	PATIENT DAYS	463,927	14	4,609		38,834	386	4
5	24	SEMINAR EXPENSE	PATIENT DAYS	463,927	14	4,112		38,834	344	5
6	25	AUTO & TRAVEL EXPENSE	PATIENT DAYS	463,927	14	20,788		38,834	1,740	6
7	32	INTEREST	PATIENT DAYS	463,927	14	(17,495)		38,834	(1,464)	7
8	35	AUTO RENTAL	PATIENT DAYS	463,927	14	85		38,834	7	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	$		$ 31,948	25

Facility Name & ID Number Rosewood Care Center Of Elgin # 0049346 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	$	37,675	$ 356	1
2	20	LICENSES	ACTUAL FEES	667,999	13	1,000		37,675	56	2
3	21	OFFICE SALARIES	ACTUAL FEES	667,999	13	218,085	218,085	37,675	12,300	3
4	21	OFFICE EXPENSE	ACTUAL FEES	667,999	13	4,612		37,675	260	4
5	24	SEMINAR	ACTUAL FEES	667,999	13	1,281		37,675	72	5
6	25	AUTO / TRAVEL EXPENSE	ACTUAL FEES	667,999	13	13,694		37,675	772	6
7	27	EMPLOYEE BENEFITS	ACTUAL FEES	667,999	13	13,112		37,675	739	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		$ 14,555	25

Facility Name & ID Number Rosewood Care Center Of Elgin # 0049346 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	$	87,691	$ 285	1
2	6	MAINTENANCE SALARY	ACTUAL FEES	929,714	14	435,123	435,123	87,691	41,041	2
3	6	MAINTENANCE EXPENSE	ACTUAL FEES	929,714	14	44,153		87,691	4,165	3
4	7	MAINTENANCE BENEFITS	ACTUAL FEES	929,714	14	61,694		87,691	5,819	4
5	19	PROFESSIONAL FEES	ACTUAL FEES	929,714	14	1,467		87,691	138	5
6	20	LICENSES	ACTUAL FEES	929,714	14	1,402		87,691	132	6
7	21	OFFICE EXPENSE	ACTUAL FEES	929,714	14	5,306		87,691	500	7
8	25	AUTO / TRAVEL EXPENSE	ACTUAL FEES	929,714	14	36,073		87,691	3,402	8
9	26	INSURANCE	ACTUAL FEES	929,714	14	12,121		87,691	1,143	9
10	30	DEPRECIATION	ACTUAL FEES	929,714	14	13,517		87,691	1,275	10
11	35	AUTO LEASE	ACTUAL FEES	929,714	14	135		87,691	13	11
12	6	MAINTENANCE SUPPLIES	DIRECT ALLOCATION		13	6,541			1,115	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		$ 59,028	25

Facility Name & ID Number Rosewood Care Center Of Elgin # 0049346 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 Elgin # 0049346 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 Elgin # 0049346 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 Elgin # 0049346 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 Elgin # 0049346 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	72580.21	8/1/04	$ 5,558,983	$ 13,720,460	9/1/39	0.0239	$ 327,629	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MidCap		X	Revolving Line of Credit							82,944	6
7	Allocated from Midwest Admin Services, Inc										21,270	7
8												8
9	TOTAL Facility Related				72580.21		$ 5,558,983	$ 13,720,460			$ 431,843	9
	B. Non-Facility Related*											
10	Less: Interest Income										(298,678)	10
11	Interest Income - Bldg. Co										(125)	11
12	Allocated from Bravo Holding Company										(1,464)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (300,267)	14
15	TOTALS (line 9+line14)						$ 5,558,983	$ 13,720,460			$ 131,576	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 68,300 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 Elgin # 0049346 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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Rosewood Care Center Of Elgin **#** 0049346 **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.**	$ 122,526	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.)		$ 132,652	2
3. Under or (over) accrual (line 2 minus line 1).		$ 10,126	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 113,613	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.		$ 123,739	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	110,779	8
	2012	109,448	9
	2013	100,985	10
	2014	121,313	11
	2015	143,991	12

Accrual based on prior year tax bill.

Line 2 reflects the second installment of the 2014 tax bill and the first installment of 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 Elgin COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0049346

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-09-100-021	Long Term Care Facility	$ 143,990.96	$ 143,990.96
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 143,990.96	$ 143,990.96

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 Elgin COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0049346

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 Elgin # 0049346 Report Period Beginning: 07/01/15 Ending: 06/30/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,268 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 [ ] NO
If so, please complete the following:

1. Total Amount Incurred:
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	Facility	206,817	2013	$ 590,758	1
2					2
3	TOTALS	206,817		$ 590,758	3

Facility Name & ID Number Rosewood Care Center Of Elgin # 0049346 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	139		2013	1994	$ 2,778,942	$ 204,408	40	$ 69,474	$ (134,934)	$ 173,685	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2009	2,785		20	398	398	2,620	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 Elgin # 0049346 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)		80,395			6,268	6,268	13,115	67
68	Related Party Allocations (Pages 12H & 12I)								68
69	Financial Statement Depreciation			14,426			(14,426)		69
70	TOTAL (lines 4 thru 69)		$ 2,862,122	$ 218,834		$ 76,140	$ (142,694)	$ 189,420	70

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

Facility Name & ID Number Rosewood Care Center Of Elgin # 0049346 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		$ 2,862,122	$ 218,834		$ 76,140	$ (142,694)	$ 189,420	1
2	Design Dev. Including Architectual, Structual, Mechanical,	2014	8,071		20	1,153	1,153	2,210	2
3	Electrical & Interior Design. Review Of Infrastructure.	2014			20				3
4	Replace Wallcoverings Main Dining & Assisted Dining Rooms	2014	7,909		20	1,130	1,130	2,072	4
5	Diagnose/Replace Cable Wires For Fax Machine	2015	4,326		20	216	216	216	5
6	Control Board Kit/Capacitor/Motor	2015	2,582		20	129	129	129	6
7	Control Board Kit/Circuit Board/Dc Relay Assembly/ Thermostat	2016	4,039		20	202	202	202	7
8	Compressor Rotary/Reversing Valve/Solenoid Coil & Motor 1/4 Hp	2016	2,742		20	137	137	137	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)		$ 2,891,792	$ 218,834		$ 79,107	$ (139,727)	$ 194,386	34

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

Facility Name & ID Number Rosewood Care Center Of Elgin # 0049346 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		$ 2,891,792	$ 218,834		$ 79,107	$ (139,727)	$ 194,386	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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,891,792	$ 218,834		$ 79,107	$ (139,727)	$ 194,386	34

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

Facility Name & ID Number Rosewood Care Center Of Elgin # 0049346 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		$ 2,891,792	$ 218,834		$ 79,107	$ (139,727)	$ 194,386	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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,891,792	$ 218,834		$ 79,107	$ (139,727)	$ 194,386	34

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

Facility Name & ID Number Rosewood Care Center Of Elgin # 0049346 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		$ 2,891,792	$ 218,834		$ 79,107	$ (139,727)	$ 194,386	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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,891,792	$ 218,834		$ 79,107	$ (139,727)	$ 194,386	34

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

Facility Name & ID Number Rosewood Care Center Of Elgin # 0049346 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	Boiler Replacement	2013	2,954		40	74	74	191	9
10	Drain Piping	2014	3,989		40	100	100	242	10
11	Cat Iron Drain	2014	3,324		40	83	83	201	11
12	HVAC Improvements	2014	5,310		10	531	531	1,328	12
13	Sprinkler	2014	47,526		10	4,753	4,753	9,902	13
14	Seal Coating	2014	6,062		25	242	242	424	14
15	Replaced Water Source Heat Pump - 200 Corridor	2014	2,730		10	273	273	455	15
16	Roof Repairs - Kitchen / Dining Room	2014	8,500		40	213	213	372	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)		$ 80,395	$		$ 6,268	$ 6,268	$ 13,115	34

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

Facility Name & ID Number Rosewood Care Center Of Elgin # 0049346 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		$ 80,395	$		$ 6,268	$ 6,268	$ 13,115	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
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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)		$ 80,395	$		$ 6,268	$ 6,268	$ 13,115	34

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

Facility Name & ID Number Rosewood Care Center Of Elgin # 0049346 Report Period Beginning: 07/01/15 Ending: 06/30/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
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)		$	$		$	$	$	34

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

Facility Name & ID Number Rosewood Care Center Of Elgin # 0049346 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
14									14
15									15
16									16
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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)		$	$		$	$	$	34

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

Facility Name & ID Number Rosewood Care Center Of Elgin # 0049346 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	$ 102,076	$ 3,379	$ 17,492	$ 14,113	10	$ 52,109	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	19,464	144	144		10	19,464	73
74								74
75	TOTALS	$ 121,540	$ 3,523	$ 17,636	$ 14,113		$ 71,573	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	$ 59,089	$ 15,065	$ 15,065	$	5	$ 38,405	76
77		Allocated from Senior Living Ser	Various	14,118	1,275	1,275		5	13,210	77
78										78
79										79
80	TOTALS			$ 73,207	$ 16,340	$ 16,340	$		$ 51,615	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)	$ 3,677,297	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 238,697	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 113,083	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (125,614)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 317,574	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 Elgin # 0049346 Report Period Beginning: 07/01/15 Ending: 06/30/16

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Off-Site Storage				2,349			5
6	Allocated from Midwest Admin Services, Inc				17,286			6
7	TOTAL				$ 19,635 **			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: $ 195 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Bravo Nursing Home Services		$	$ 11	17
18	Allocated from Bravo Holding Company			7	18
19	Allocated from Senior Living Services, Inc.			13	19
20					20
21	TOTAL		$	$ 31	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 Elgin # 0049346 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 Elgin # 0049346 Report Period Beginning: 07/01/15 Ending: 06/30/16

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 370,498	$		$ 370,498	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			106,491			106,491	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			391,725			391,725	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				385,962		385,962	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					14,397	32,134		46,531	13
14	TOTAL			$		$ 883,111	$ 418,096		$ 1,301,207	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 Elgin # 0049346 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	$ 1,053	$ 3,726	1
2	Cash-Patient Deposits	500	500	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,957,288	1,957,288	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	50,652	54,428	6
7	Other Prepaid Expenses	4,447	180,892	7
8	Accounts Receivable (owners or related parties)	6,083,881	6,084,181	8
9	Other(specify): See Attached Schedule	11,959	12,259	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 8,109,780	$ 8,293,274	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		590,758	13
14	Buildings, at Historical Cost		4,590,032	14
15	Leasehold Improvements, at Historical Cost	18,765	620,145	15
16	Equipment, at Historical Cost	56,207	899,531	16
17	Accumulated Depreciation (book methods)	(44,352)	(3,499,852)	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):		381,928	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 30,620	$ 3,582,542	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,140,400	$ 11,875,816	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,613,113	$ 2,706,222	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	238,349	238,349	30
31	Accrued Taxes Payable (excluding real estate taxes)	225,198	225,198	31
32	Accrued Real Estate Taxes(Sch.IX-B)		113,613	32
33	Accrued Interest Payable		369,253	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	9,212	9,212	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	2,221,227	296,668	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,307,099	$ 3,958,515	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		13,720,460	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)**	$	$ 13,720,460	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,307,099	$ 17,678,975	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,833,301	$ (5,803,159)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,140,400	$ 11,875,816	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,931,682	1
2	Restatements (describe):		2
3	Equity Adjustment	(8,291)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,923,391	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(90,090)	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)**	$ (90,090)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,833,301	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	$ 9,672,237	1
2	Discounts and Allowances for all Levels	(2,892,234)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,780,003	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,440,859	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,440,859	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,200	13
14	Non-Patient Meals	3,134	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	437,262	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	87,796	19
20	Radiology and X-Ray	22,635	20
21	Other Medical Services	119,183	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 672,210	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	298,678	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 298,678	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	8,444	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 8,444	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,200,194	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,586,953	31
32	Health Care	4,041,785	32
33	General Administration	1,982,502	33
	B. Capital Expense		
34	Ownership	1,019,263	34
	C. Ancillary Expense		
35	Special Cost Centers	1,390,505	35
36	Provider Participation Fee	269,276	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,290,284	40
41	**Income before Income Taxes (line 30 minus line 40)****	(90,090)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (90,090)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,423,823	44
45	Private Pay - Net Inpatient Revenue	2,794,131	45
46	Medicare - Net Inpatient Revenue	1,277,584	46
47	Other-(specify) Insurance/ Managed Care	284,465	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,780,003	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	2,128	2,292	$ 94,786	$ 41.36	1
2	Assistant Director of Nursing	1,784	1,892	66,809	35.31	2
3	Registered Nurses	45,330	49,089	1,393,748	28.39	3
4	Licensed Practical Nurses	20,088	21,545	512,793	23.80	4
5	CNAs & Orderlies	79,093	84,066	1,018,763	12.12	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,131	8,698	186,476	21.44	8
9	Activity Director	2,084	2,268	34,510	15.22	9
10	Activity Assistants	3,294	3,509	30,829	8.79	10
11	Social Service Workers	4,808	5,420	106,306	19.61	11
12	Dietician					12
13	Food Service Supervisor	158	191	4,222	22.10	13
14	Head Cook					14
15	Cook Helpers/Assistants	2,306	2,957	29,099	9.84	15
16	Dishwashers					16
17	Maintenance Workers	2,197	2,458	34,587	14.07	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,224	2,408	110,512	45.89	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,447	10,296	141,687	13.76	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	2,026	2,387	47,378	19.85	31
32	Other Health Care(specify)					32
33	Other(specify)	4,043	4,259	87,877	20.63	33
34	TOTAL (lines 1 - 33)	189,141	203,735	$ 3,900,382 *	$ 19.14	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 7,015	01-03	35
36	Medical Director	Monthly	12,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	9,717	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	2,676	11-03	44
45	Social Service Consultant	Monthly	2,200	12-03	45
46	Other(specify) Outsourced Dietary	Monthly	436,641	01-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 470,249		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	75	$ 4,497	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	7,825	196,410	10-03	52
53	TOTAL (lines 50 - 52)	7,900	$ 200,907		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Peggy Aschenbenner	Administrator		$ 110,512
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 110,512

B. Administrative - Other

Description	Amount
Mgmt Fees - Bravo Nursing Home Services	$ 138,000
Mgmt Fees - Midwest Admin Services	293,945
TOTAL (agree to Schedule V, line 17, col. 3)	$ 431,945
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Mulherin, Rehfeldt & Varchetto	Legal Fees	$ 3,302
Daniel Maher	Legal Fees	7,508
Janson Reporting Service LTD	Court Reporter	584
Claims Administration Services	Related Party Legal Fees	(58,511)
Infinite Solutions Support	Technology Consulting	23,509
Dr. Robert Alfred Beatty	Professional Services	3,500
ADR Systems	Mediation Services	2,695
Karen Hess	Lawsuit Settlement	30,000
Kanu Panchal	Deposition Appearance Fee	1,500
Daniel Hayes	Lawsuit Settlement	13,406
Larry Templin	Accounting	1,856
See Supplemental Schedule		54,950
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 84,299

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 103,334
Unemployment Compensation Insurance	35,516
FICA Taxes	291,061
Employee Health Insurance	68,291
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Uniforms	1,090
Employee Relations	5,038
401K Expense	16,871
Dental Insurance	3,080
Employee Physicals & Vaccinations	9,768
TOTAL (agree to Schedule V, line 22, col.8)	$ 534,050

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	$
Advertising: Employee Recruitment	7,733
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Dues & Subscriptions	5,469
State Police Reports	6,879
Allocated from Midwest Admin Services	2,736
Allocated from Bravo Nursing Home Services	2
See Supplemental Schedule	473
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,291

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,471
Allocated from Midwest Admin Services	561
Allocated from Bravo Nursing Home Services	198
See Supplemental Schedule	416
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,646

* 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: $8,190.66**

(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**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **70,991** 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. $ **269,276**
This amount is to be recorded on line 42 of Schedule V.

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

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **3,134**

(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