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: 0049320

Facility Name: Rosewood Care Center Of St. Charles

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

County: Kane

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

HFS ID Number: [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 St. Charles # 0049320 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	109	Skilled (SNF)	109	39,894	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	109	TOTALS	109	39,894	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	15,178	7,028	7,541	29,747	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,178	7,028	7,541	29,747	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.57%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

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

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/1/07

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 49 and days of care provided 5,596

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: 6/30/16 Fiscal Year: 6/30/16

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

Facility Name & ID Number Rosewood Care Center Of St. Charles # 0049320 Report Period Beginning: 07/01/15 Ending: 06/30/16

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	25,457	5,978	360,346	391,781		391,781	417	392,198			1
2	Food Purchase		213,194		213,194		213,194	(8,032)	205,162			2
3	Housekeeping		17,418	172,762	190,180		190,180		190,180			3
4	Laundry			115,174	115,174		115,174		115,174			4
5	Heat and Other Utilities			176,492	176,492		176,492	(9,587)	166,905			5
6	Maintenance	40,247	16,692	258,610	315,549		315,549	(77,269)	238,280			6
7	Other (specify):*							5,492	5,492			7
8	TOTAL General Services	65,704	253,282	1,083,384	1,402,370		1,402,370	(88,979)	1,313,391			8
	B. Health Care and Programs											
9	Medical Director			2,581	2,581		2,581		2,581			9
10	Nursing and Medical Records	2,386,642	254,198	75,112	2,715,952		2,715,952	26,543	2,742,495			10
10a	Therapy	74,944	1,545		76,489		76,489		76,489			10a
11	Activities	73,029	4,874	2,060	79,963		79,963		79,963			11
12	Social Services	73,953		2,700	76,653		76,653		76,653			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							2,596	2,596			15
16	TOTAL Health Care and Programs	2,608,568	260,617	82,453	2,951,638		2,951,638	29,139	2,980,777			16
	C. General Administration											
17	Administrative	113,020		373,466	486,486		486,486	(326,046)	160,440			17
18	Directors Fees											18
19	Professional Services			112,991	112,991		112,991	(25,770)	87,221			19
20	Dues, Fees, Subscriptions & Promotions			20,642	20,642		20,642	(538)	20,104			20
21	Clerical & General Office Expenses	109,058	28,383	557,192	694,633		694,633	(385,500)	309,133			21
22	Employee Benefits & Payroll Taxes			377,716	377,716		377,716		377,716			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,655	1,655		1,655	881	2,536			24
25	Other Admin. Staff Transportation			4,717	4,717		4,717	6,238	10,955			25
26	Insurance-Prop.Liab.Malpractice			57,097	57,097		57,097	13,933	71,030			26
27	Other (specify):*							21,038	21,038			27
28	TOTAL General Administration	222,078	28,383	1,505,476	1,755,937		1,755,937	(695,766)	1,060,171			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,896,350	542,282	2,671,313	6,109,945		6,109,945	(755,606)	5,354,339			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 St. Charles #0049320 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			15,509	15,509		15,509	125,553	141,062			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			267,923	267,923		267,923	535,197	803,120			32
33	Real Estate Taxes							151,170	151,170			33
34	Rent-Facility & Grounds			1,118,158	1,118,158		1,118,158	(1,097,517)	20,641			34
35	Rent-Equipment & Vehicles							26	26			35
36	Other (specify):*			26,929	26,929		26,929	33,439	60,368			36
37	**TOTAL Ownership**			1,428,519	1,428,519		1,428,519	(252,132)	1,176,387			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		284,558	834,538	1,119,096		1,119,096		1,119,096			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			209,938	209,938		209,938		209,938			42
43	Other (specify):*	91,586		2,239	93,825		93,825	(93,825)	(0)			43
44	**TOTAL Special Cost Centers**	91,586	284,558	1,046,715	1,422,859		1,422,859	(93,825)	1,329,034			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,987,936	826,840	5,146,547	8,961,323		8,961,323	(1,101,563)	7,859,760			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 St. Charles # 0049320 Report Period Beginning: 07/01/15 Ending: 06/30/16

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,291)	02		4
5	Telephone, TV & Radio in Resident Rooms	(9,996)	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	(130,157)	30		9
10	Interest and Other Investment Income	(77)	32		10
11	Discounts, Allowances, Rebates & Refunds	(6,065)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(504)	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	(643)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(509,627)	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	(654)	20		28
29	Other-Attach Schedule	(214,188)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (873,202)		$	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)	(228,362)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (228,362)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,101,564)		37

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

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

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

STATE OF ILLINOIS

Rosewood Care Center Of St. Charles

ID# 0049320

Report Period Beginning: 07/01/15

Ending: 06/30/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Salary	$ (91,586)	43	1
2	Marketing Expenses	(2,239)	43	2
3	Bank Charges	(6,365)	21	3
4	Vending Income	(172)	02	4
5	Miscellaneous Income	(1,414)	21	5
6	Midcap Line of Credit Fees	(26,929)	36	6
7	Vendor Late Charges	(13,671)	21	7
8	Bldg Co - Audit Fees	(4,100)	19	8
9	Bldg Co - Prof Fees	(1,501)	19	9
10	Bldg Co - Bank Charges	(15,260)	21	10
11	Bldg Co - Amortization	(5,071)	36	11
12	Marketing Travel	(3,582)	25	12
13	Capitalized R&M	(37,840)	06	13
14	PAC Dues	(2,351)	20	14
15	Non Allowable Legal	(2,106)	19	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(214,188)		49

Rosewood Care Center Of St. Charles

ID# 0049320

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 St. Charles # 0049320 **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				417								417	1
2	Food Purchase	(8,032)											(8,032)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(9,996)		143				266					(9,587)	5
6	Maintenance	(37,840)		86				(39,515)					(77,269)	6
7	Other (specify):*				44			5,448					5,492	7
8	**TOTAL General Services**	(55,868)		229	461			(33,801)					(88,979)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				26,543								26,543	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				2,596								2,596	15
16	**TOTAL Health Care and Programs**				29,139								29,139	16
	C. General Administration													
17	Administrative			(235,466)	(96,992)	6,412							(326,046)	17
18	Directors Fees													18
19	Professional Services	(7,707)	5,601	104	75	17,066	(41,038)	130					(25,770)	19
20	Fees, Subscriptions & Promotions	(3,005)		2,096	2	219	27	124					(538)	20
21	Clerical & General Office Expenses	(546,980)	22,460	131,767	418	296	6,071	469					(385,500)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			430	152	264	35						881	24
25	Other Admin. Staff Transportation	(3,582)		2,177	2,751	1,333	373	3,185					6,238	25
26	Insurance-Prop.Liab.Malpractice		9,090	3,772				1,070					13,933	26
27	Other (specify):*			17,381	3,299		357						21,038	27
28	**TOTAL General Administration**	(561,274)	37,151	(77,740)	(90,295)	25,589	(34,174)	4,977					(695,766)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(617,142)	37,151	(77,511)	(60,695)	25,589	(34,174)	(28,824)					(755,606)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Center Of St. Charles # 0049320 **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	(130,157)	240,278	14,238				1,194					125,553	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(77)	520,103	16,293		(1,122)							535,197	32
33	Real Estate Taxes		151,170										151,170	33
34	Rent-Facility & Grounds		(1,110,758)	13,241									(1,097,517)	34
35	Rent-Equipment & Vehicles				8	5		12					26	35
36	Other (specify):*	(32,000)	65,439										33,439	36
37	**TOTAL Ownership**	(162,234)	(133,768)	43,772	8	(1,116)		1,206					(252,132)	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):*	(93,825)											(93,825)	43
44	**TOTAL Special Cost Centers**	(93,825)											(93,825)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(873,202)	(96,617)	(33,739)	(60,686)	24,473	(34,174)	(27,618)					(1,101,563)	45

Facility Name & ID Number Rosewood Care Center Of St. Charles # 0049320 Report Period Beginning: 07/01/15 Ending: 06/30/16

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 1,110,758	St. Charles Real Estate	100.00%	$	$ (1,110,758)	1
2	V	32	Interest	28	St. Charles Real Estate	100.00%	520,131	520,103	2
3	V	19	Audit Fees		St. Charles Real Estate	100.00%	4,100	4,100	3
4	V	19	Professional Fees		St. Charles Real Estate	100.00%	1,501	1,501	4
5	V	21	Bank Charges		St. Charles Real Estate	100.00%	15,260	15,260	5
6	V	33	Real Estate Tax		St. Charles Real Estate	100.00%	151,170	151,170	6
7	V	30	Depreciation		St. Charles Real Estate	100.00%	240,278	240,278	7
8	V	36	Amortization Loan Fee		St. Charles Real Estate	100.00%	5,071	5,071	8
9	V	21	Base Admin Fee (Page 6A)		St. Charles Real Estate	100.00%	7,200	7,200	9
10	V	26	Insurance Expense - Property		St. Charles Real Estate	100.00%	9,090	9,090	10
11	V	36	Interest Exp-HUD MIP		St. Charles Real Estate	100.00%	60,368	60,368	11
12	V								12
13	V								13
14	Total			$ 1,110,786			$ 1,014,169	$ * (96,617)	14

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

Facility Name & ID Number Rosewood Care Center Of St. Charles # 0049320 Report Period Beginning: 07/01/15 Ending: 06/30/16

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	$ 143	$ 143	15
16	V	6	MAINTENANCE EXPENSE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	86	86	16
17	V	19	PROFESSIONAL FEES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	104	104	17
18	V	20	DUES, SUBSCRIPTIONS, LICENSES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	2,096	2,096	18
19	V	21	OFFICE SALARIES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	109,434	109,434	19
20	V	21	OFFICE EXPENSES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	29,533	29,533	20
21	V	24	SEMINAR		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	430	430	21
22	V	25	TRAVEL EXPENSE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	2,177	2,177	22
23	V	26	INSURANCE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	3,772	3,772	23
24	V	27	EMPLOYEE BENEFITS		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	17,381	17,381	24
25	V	30	DEPRECIATION		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	14,238	14,238	25
26	V	32	INTEREST		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	16,293	16,293	26
27	V	34	BUILDING RENT		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	13,241	13,241	27
28	V								28
29	V	17	ADMINISTRATIVE FEE	235,466	MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%		(235,466)	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			$ 242,666			$ 208,927	$ * (33,739)	39

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

Facility Name & ID Number Rosewood Care Center Of St. Charles # 0049320 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%	$ 417	$ 417	15
16	V	7	DIETARY BENEFITS		BRAVO NURSING HOME SERVICES, INC.	100.00%	44	44	16
17	V	10	CORPORATE RN SALARIES		BRAVO NURSING HOME SERVICES, INC.	100.00%	26,543	26,543	17
18	V	15	CORPORATE RN SALARIES BENEFITS		BRAVO NURSING HOME SERVICES, INC.	100.00%	2,596	2,596	18
19	V	17	ADMINISTRATIVE SALARIES		BRAVO NURSING HOME SERVICES, INC.	100.00%	41,008	41,008	19
20	V	19	PROFESSIONAL FEES		BRAVO NURSING HOME SERVICES, INC.	100.00%	75	75	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%	418	418	22
23	V	24	SEMINAR & LODGING EXPENSE		BRAVO NURSING HOME SERVICES, INC.	100.00%	152	152	23
24	V	25	AUTO EXPENSE		BRAVO NURSING HOME SERVICES, INC.	100.00%	2,751	2,751	24
25	V	27	ADMINISTRATIVE & OFFICE BENEFITS		BRAVO NURSING HOME SERVICES, INC.	100.00%	3,299	3,299	25
26	V	35	AUTO LEASE		BRAVO NURSING HOME SERVICES, INC.	100.00%	8	8	26
27	V								27
28	V	17	ADMINISTRATIVE FEE	138,000	BRAVO NURSING HOME SERVICES, INC.	100.00%		(138,000)	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 138,000			$ 77,314	$ * (60,686)	39

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

Facility Name & ID Number Rosewood Care Center Of St. Charles # 0049320 Report Period Beginning: 07/01/15 Ending: 06/30/16

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	CONSULTING FEES	$	BRAVO HOLDING COMPANY	100.00%	$ 6,412	$ 6,412	15
16	V	19	PROFESSIONAL FEES		BRAVO HOLDING COMPANY	100.00%	17,066	17,066	16
17	V	20	DUES & SUBSCRIPTIONS		BRAVO HOLDING COMPANY	100.00%	219	219	17
18	V	21	OFFICE EXPENSE		BRAVO HOLDING COMPANY	100.00%	296	296	18
19	V	24	SEMINAR EXPENSE		BRAVO HOLDING COMPANY	100.00%	264	264	19
20	V	25	AUTO & TRAVEL EXPENSE		BRAVO HOLDING COMPANY	100.00%	1,333	1,333	20
21	V	32	INTEREST		BRAVO HOLDING COMPANY	100.00%	(1,122)	(1,122)	21
22	V	35	AUTO RENTAL		BRAVO HOLDING COMPANY	100.00%	5	5	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 24,473	$ * 24,473	39

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

Facility Name & ID Number Rosewood Care Center Of St. Charles # 0049320 Report Period Beginning: 07/01/15 Ending: 06/30/16

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	$ 172	$ 172	15
16	V	20	LICENSES		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	27	27	16
17	V	21	OFFICE SALARIES		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	5,945	5,945	17
18	V	21	OFFICE EXPENSE		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	126	126	18
19	V	24	SEMINAR		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	35	35	19
20	V	25	AUTO / TRAVEL EXPENSE		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	373	373	20
21	V	27	EMPLOYEE BENEFITS		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	357	357	21
22	V								22
23	V	19	PROFESSIONAL FEES	41,210	CLAIMS ADMINISTRATION SERVICES, LLC	100.00%		(41,210)	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			$ 41,210			$ 7,036	$ * (34,174)	39

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

Facility Name & ID Number Rosewood Care Center Of St. Charles # 0049320 Report Period Beginning: 07/01/15 Ending: 06/30/16

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	SENIOR LIVING SERVICES, INC.	100.00%	$ 266	$ 266	15
16	V	6	MAINTENANCE SALARY		SENIOR LIVING SERVICES, INC.	100.00%	38,422	38,422	16
17	V	6	MAINTENANCE EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	3,899	3,899	17
18	V	7	MAINTENANCE BENEFITS		SENIOR LIVING SERVICES, INC.	100.00%	5,448	5,448	18
19	V	19	PROFESSIONAL FEES		SENIOR LIVING SERVICES, INC.	100.00%	130	130	19
20	V	20	LICENSES		SENIOR LIVING SERVICES, INC.	100.00%	124	124	20
21	V	21	OFFICE EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	469	469	21
22	V	25	AUTO / TRAVEL EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	3,185	3,185	22
23	V	26	INSURANCE		SENIOR LIVING SERVICES, INC.	100.00%	1,070	1,070	23
24	V	30	DEPRECIATION		SENIOR LIVING SERVICES, INC.	100.00%	1,194	1,194	24
25	V	35	AUTO LEASE		SENIOR LIVING SERVICES, INC.	100.00%	12	12	25
26	V	6	MAINTENANCE SUPPLIES		SENIOR LIVING SERVICES, INC.	100.00%	259	259	26
27	V								27
28	V	6	MAINTENANCE SERVICES	82,096	SENIOR LIVING SERVICES, INC.	100.00%		(82,096)	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			$ 82,096			$ 54,478	$ * (27,618)	39

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

Facility Name & ID Number Rosewood Care Center Of St. Charles # 0049320 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 St. Charles # 0049320 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 St. Charles # 0049320 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 St. Charles # 0049320 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 St. Charles # 0049320 Report Period Beginning: 07/01/15 Ending: 06/30/16

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Hinde Feiner	50.00%	Bravo Care of Alton, Inc.	Alton, IL	St. Charles Real Estate		Lessor	1
2	Hillel Yampol	50.00%	Bravo Care of East Peoria, Inc.	East Peoria, IL	Bravo Administrative Services, Inc.	St. Louis, MO	Administration	2
3			Bravo Care of Edwardsville, Inc.	Edwardsville, IL	Bravo Holding Company, Inc.	St. Louis, MO	Holding Company	3
4			Bravo Care of Elgin, Inc.	Elgin, IL	Bravo Nursing Home Services, Inc.	St. Louis, MO	Management	4
5			Bravo Care of Galesburg, Inc.	Galesburg, IL	Bravo Team Health, Inc.	St. Louis, MO	Human Resources	5
6			Bravo Care of Inverness, Inc.	Inverness, IL	Claims Administration Services, LLC.	St. Louis, MO	Legal Services	6
7			Bravo Care of Joliet, Inc.	Joliet, IL	Senior Living Services, Inc.	St. Louis, MO	Building Services	7
8			Bravo Care of Moline, Inc.	Moline, IL	Midwest Administrative Services, Inc.	St. Louis, MO	Administration	8
9			Bravo Care of Northbrook, Inc.	Northbrook, IL	Bravo Care of Wood River, Inc.	Wood River, IL	Supportive Living Facility	9
10			Bravo Care of Peoria, Inc.	Peoria, IL	Rosewood Home Health Services, Inc.	Edwardsville, IL	Home Health	10
11			Bravo Care of Rockford, Inc.	Rockford, 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 St. Charles # 0049320 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 St. Charles # 0049320 Report Period Beginning: 07/01/15 Ending: 06/30/16

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Hillel Yampol	Shareholder	Administrative	50.00%	See Attached	1.28	6.41%	Alloc. Salary	$ 1,455	17-7	1
2	Mark Yampol	Relative	Administrative	0	See Attached	1.28	6.41%	Alloc. Fees	6,412	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 7,867		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 St. Charles # 0049320 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 St. Charles # 0049320 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	$	29,747	$ 143	1
2	6	MAINTENANCE EXPENSE	PAT. DAYS	463,927	14	1,345		29,747	86	2
3	19	PROFESSIONAL FEES	PAT. DAYS	463,927	14	1,614		29,747	104	3
4	20	DUES, SUBSCRIPTIONS, LICEN	PAT. DAYS	463,927	14	32,685		29,747	2,096	4
5	21	OFFICE SALARIES	PAT. DAYS	463,927	14	1,706,712	1,706,712	29,747	109,434	5
6	21	OFFICE EXPENSES	PAT. DAYS	463,927	14	460,588		29,747	29,533	6
7	24	SEMINAR	PAT. DAYS	463,927	14	6,706		29,747	430	7
8	25	TRAVEL EXPENSE	PAT. DAYS	463,927	14	33,946		29,747	2,177	8
9	26	INSURANCE	PAT. DAYS	463,927	14	58,834		29,747	3,772	9
10	27	EMPLOYEE BENEFITS	PAT. DAYS	463,927	14	271,068		29,747	17,381	10
11	30	DEPRECIATION	PAT. DAYS	463,927	14	222,055		29,747	14,238	11
12	32	INTEREST	PAT. DAYS	463,927	14	254,102		29,747	16,293	12
13	34	BUILDING RENT	PAT. DAYS	463,927	14	206,500		29,747	13,241	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		$ 208,928	25

Facility Name & ID Number Rosewood Care Center Of St. Charles # 0049320 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	29,747	$ 417	1
2	7	DIETARY BENEFITS	PAT. DAYS	463,927	14	687		29,747	44	2
3	10	CORPORATE RN SALARIES	PAT. DAYS	463,927	14	413,960	413,960	29,747	26,543	3
4	15	CORPORATE RN SALARIES BE	PAT. DAYS	463,927	14	40,484		29,747	2,596	4
5	17	ADMINISTRATIVE SALARIES	PAT. DAYS	463,927	14	639,544	639,544	29,747	41,008	5
6	19	PROFESSIONAL FEES	PAT. DAYS	463,927	14	1,170		29,747	75	6
7	20	DUES & SUBSCRIPTIONS	PAT. DAYS	463,927	14	27		29,747	2	7
8	21	OFFICE EXPENSES	PAT. DAYS	463,927	14	6,517		29,747	418	8
9	24	SEMINAR & LODGING EXPEN	PAT. DAYS	463,927	14	2,370		29,747	152	9
10	25	AUTO EXPENSE	PAT. DAYS	463,927	14	42,910		29,747	2,751	10
11	27	ADMINISTRATIVE & OFFICE I	PAT. DAYS	463,927	14	51,458		29,747	3,299	11
12	35	AUTO LEASE	PAT. DAYS	463,927	14	133		29,747	8	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,205,766	$ 1,060,009		$ 77,313	25

Facility Name & ID Number Rosewood Care Center Of St. Charles # 0049320 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	$	29,747	$ 6,412	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	463,927	14	266,160		29,747	17,066	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	463,927	14	3,410		29,747	219	3
4	21	OFFICE EXPENSE	PATIENT DAYS	463,927	14	4,609		29,747	296	4
5	24	SEMINAR EXPENSE	PATIENT DAYS	463,927	14	4,112		29,747	264	5
6	25	AUTO & TRAVEL EXPENSE	PATIENT DAYS	463,927	14	20,788		29,747	1,333	6
7	32	INTEREST	PATIENT DAYS	463,927	14	(17,495)		29,747	(1,122)	7
8	35	AUTO RENTAL	PATIENT DAYS	463,927	14	85		29,747	5	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 381,668	$		$ 24,473	25

Facility Name & ID Number Rosewood Care Center Of St. Charles # 0049320 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	$	18,210	$ 172	1
2	20	LICENSES	ACTUAL FEES	667,999	13	1,000		18,210	27	2
3	21	OFFICE SALARIES	ACTUAL FEES	667,999	13	218,085	218,085	18,210	5,945	3
4	21	OFFICE EXPENSE	ACTUAL FEES	667,999	13	4,612		18,210	126	4
5	24	SEMINAR	ACTUAL FEES	667,999	13	1,281		18,210	35	5
6	25	AUTO / TRAVEL EXPENSE	ACTUAL FEES	667,999	13	13,694		18,210	373	6
7	27	EMPLOYEE BENEFITS	ACTUAL FEES	667,999	13	13,112		18,210	357	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		$ 7,035	25

Facility Name & ID Number Rosewood Care Center Of St. Charles # 0049320 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	$	82,096	$ 266	1
2	6	MAINTENANCE SALARY	ACTUAL FEES	929,714	14	435,123	435,123	82,096	38,422	2
3	6	MAINTENANCE EXPENSE	ACTUAL FEES	929,714	14	44,153		82,096	3,899	3
4	7	MAINTENANCE BENEFITS	ACTUAL FEES	929,714	14	61,694		82,096	5,448	4
5	19	PROFESSIONAL FEES	ACTUAL FEES	929,714	14	1,467		82,096	130	5
6	20	LICENSES	ACTUAL FEES	929,714	14	1,402		82,096	124	6
7	21	OFFICE EXPENSE	ACTUAL FEES	929,714	14	5,306		82,096	469	7
8	25	AUTO / TRAVEL EXPENSE	ACTUAL FEES	929,714	14	36,073		82,096	3,185	8
9	26	INSURANCE	ACTUAL FEES	929,714	14	12,121		82,096	1,070	9
10	30	DEPRECIATION	ACTUAL FEES	929,714	14	13,517		82,096	1,194	10
11	35	AUTO LEASE	ACTUAL FEES	929,714	14	135		82,096	12	11
12	6	MAINTENANCE SUPPLIES	DIRECT ALLOCATION		13	6,541			259	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		$ 54,478	25

Facility Name & ID Number Rosewood Care Center Of St. Charles # 0049320 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 St. Charles # 0049320 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 St. Charles # 0049320 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 St. Charles # 0049320 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 St. Charles # 0049320 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 Payable	82,450.45	11/1/04	$ 9,101,649	$ 11,100,781	12/1/39	0.0469	$ 520,131	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Midcap		X	Line of Credit				3,295,783			111,826	6
7	Bravo Holding		X	Note Payable							156,097	7
8	See Supplemental Schedule										16,293	8
9	TOTAL Facility Related				82450.45		$ 9,101,649	$ 14,396,564			$ 804,347	9
	B. Non-Facility Related*											
10	Interest Income		X								(77)	10
11	Interest Income - Bldg Co		X								(28)	11
12												12
13	See Supplemental Schedule										(1,122)	13
14	TOTAL Non-Facility Related						$	$			$ (1,227)	14
15	TOTALS (line 9+line14)						$ 9,101,649	$ 14,396,564			$ 803,120	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 60,368 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 St. Charles # 0049320 Report Period Beginning: 07/01/15 Ending: 06/30/16

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Allocated from MAS	X					$	$			$ 16,293	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										16,293	14
	B. Non-Facility Related*											
15	Allocated from Bravo Holding C	X					$	$			$ (1,122)	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related										(1,122)	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 St. Charles # 0049320 **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.**	$ 143,335	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.)		$ 146,697	2
3. Under or (over) accrual (line 2 minus line 1).		$ 3,362	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 147,807	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.		$ 151,169	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	181,171	8
	2012	110,066	9
	2013	141,193	10
	2014	148,206	11
	2015	145,188	12

Accrual based on PY tax bill.

RE Taxes paid on Line 2 are 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 St. Charles COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0049320

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.	09-26-226-008	Long Term Care Property	$ 145,187.54	$ 145,187.54
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 145,187.54	$ 145,187.54

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 St. Charles COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0049320

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 St. Charles # 0049320 Report Period Beginning: 07/01/15 Ending: 06/30/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,252 B. General Construction Type: Exterior Brick Veneer Frame Steel Number of Stories 1

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

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

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

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

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

None

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

1. Total Amount Incurred: 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	8.35 Acres	2013	$ 1,577,420	1
2					2
3	TOTALS	#VALUE!		$ 1,577,420	3

Facility Name & ID Number Rosewood Care Center Of St. Charles # 0049320 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	109		2013	1999	$ 4,302,741	$ 240,278	40	$ 107,569	$ (132,709)	$ 268,922	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2009	4,206		20	601	601	4,056	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 St. Charles # 0049320 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)		40,452			1,400	1,400	2,779	67
68	Related Party Allocations (Pages 12H & 12I)								68
69	Financial Statement Depreciation			15,509			(15,509)		69
70	TOTAL (lines 4 thru 69)		$ 4,347,399	$ 255,787		$ 109,570	$ (146,217)	$ 275,757	70

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

Facility Name & ID Number Rosewood Care Center Of St. Charles # 0049320 Report Period Beginning: 07/01/15 Ending: 06/30/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,347,399	$ 255,787		$ 109,570	$ (146,217)	$ 275,757	1
2	Repair Broken Sewer In Dining Room Area	2015	8,192		20	410	410	410	2
3	Thermostat Valve & Compressor	2015	3,328		20	166	166	166	3
4	Pipe Repair	2016	12,619		20	631	631	631	4
5	Install 56 Ft Sewer Pipe Liner	2016	5,600		20	280	280	280	5
6	Plumbing Repair	2016	4,500		20	225	225	225	6
7	Replace Spray Pump For Cooling Tower	2016	3,601		20	180	180	180	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)		$ 4,385,239	$ 255,787		$ 111,462	$ (144,325)	$ 277,649	34

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

Facility Name & ID Number Rosewood Care Center Of St. Charles # 0049320 Report Period Beginning: 07/01/15 Ending: 06/30/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,385,239	$ 255,787		$ 111,462	$ (144,325)	$ 277,649	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)		$ 4,385,239	$ 255,787		$ 111,462	$ (144,325)	$ 277,649	34

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

Facility Name & ID Number Rosewood Care Center Of St. Charles # 0049320 Report Period Beginning: 07/01/15 Ending: 06/30/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 4,385,239	$ 255,787		$ 111,462	$ (144,325)	$ 277,649	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)		$ 4,385,239	$ 255,787		$ 111,462	$ (144,325)	$ 277,649	34

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

Facility Name & ID Number Rosewood Care Center Of St. Charles # 0049320 Report Period Beginning: 07/01/15 Ending: 06/30/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 4,385,239	$ 255,787		$ 111,462	$ (144,325)	$ 277,649	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)		$ 4,385,239	$ 255,787		$ 111,462	$ (144,325)	$ 277,649	34

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

Facility Name & ID Number Rosewood Care Center Of St. Charles # 0049320 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	Window Sills	2014	8,338		40	208	208	520	9
10	Doors	2014	4,190		40	105	105	227	10
11	Cooling Tower	2014	3,717		10	372	372	806	11
12	Concrete Sidewalk	2014	6,000		25	240	240	520	12
13	Seal Coating	2014	6,303		25	252	252	441	13
14	Replace Shower Wall	2015	5,079		40	127	127	169	14
15	Foundation Repair	2016	6,825		40	96	96	96	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)		$ 40,452	$		$ 1,400	$ 1,400	$ 2,779	34

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

Facility Name & ID Number Rosewood Care Center Of St. Charles # 0049320 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		$ 40,452	$		$ 1,400	$ 1,400	$ 2,779	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
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20									20
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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)		$ 40,452	$		$ 1,400	$ 1,400	$ 2,779	34

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

Facility Name & ID Number Rosewood Care Center Of St. Charles # 0049320 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 St. Charles # 0049320 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
17									17
18									18
19									19
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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)		$	$		$	$	$	34

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

Facility Name & ID Number Rosewood Care Center Of St. Charles # 0049320 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	$ 87,300	$ 2,588	$ 16,756	$ 14,168	10	$ 49,847	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	14,910	110	110		10	14,910	73
74								74
75	TOTALS	$ 102,210	$ 2,698	$ 16,866	$ 14,168		$ 64,757	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 MAS	2016	$ 45,263	$ 11,540	$ 11,540	$	5	$ 29,419	76
77		Allocated from Senior Living Ser	2016	13,217	1,194	1,194		5	12,367	77
78										78
79										79
80	TOTALS			$ 58,480	$ 12,734	$ 12,734	$		$ 41,786	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,123,349	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 271,219	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 141,062	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (130,157)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 384,192	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 St. Charles # 0049320 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				7,400			5
6	Allocated from MAS				13,241			6
7	TOTAL				$ 20,641 **			7

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

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

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2017	$
13.	/2018	$
14.	/2019	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Bravo Nursing Home		$	$ 8	17
18	Allocated from Bravo Holding Company			5	18
19	Allocated from Senior Living Services			12	19
20					20
21	TOTAL		$	$ 25	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 St. Charles # 0049320 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 St. Charles # 0049320 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	$		$ 341,067	$		$ 341,067	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			117,523			117,523	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			335,751			335,751	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				260,776		260,776	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					40,197	23,782		63,979	13
14	TOTAL			$		$ 834,538	$ 284,558		$ 1,119,096	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 St. Charles # 0049320 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	$ 988	$ 3,219	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,521,277	2,521,277	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	39,720	43,129	6
7	Other Prepaid Expenses	1,846	1,846	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	19,082	19,082	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,582,913	$ 2,588,553	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,577,420	13
14	Buildings, at Historical Cost		5,878,287	14
15	Leasehold Improvements, at Historical Cost	4,206	1,211,102	15
16	Equipment, at Historical Cost	67,500	840,009	16
17	Accumulated Depreciation (book methods)	(46,703)	(3,991,832)	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):		288,310	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 25,003	$ 5,803,296	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,607,916	$ 8,391,849	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,328,816	$ 2,393,195	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	3,295,783	3,295,783	29
30	Accrued Salaries Payable	144,500	144,500	30
31	Accrued Taxes Payable (excluding real estate taxes)	143,871	143,871	31
32	Accrued Real Estate Taxes(Sch.IX-B)		147,807	32
33	Accrued Interest Payable		590,166	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	12,184	12,184	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	1,478,251	283,095	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 7,403,405	$ 7,010,601	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,100,781	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 11,100,781	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,403,405	$ 18,111,382	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (4,795,489)	$ (9,719,533)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,607,916	$ 8,391,849	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,769,566)	1
2	Restatements (describe):		2
3	**Prior Year Equity Adjustments**	(17,668)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,787,234)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,008,255)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,008,255)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (4,795,489)	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	$ 7,756,548	1
2	Discounts and Allowances for all Levels	(2,957,688)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,798,860	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,697,433	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,697,433	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	3,575	13
14	Non-Patient Meals	1,291	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	277,827	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	72,699	19
20	Radiology and X-Ray	15,169	20
21	Other Medical Services	78,486	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 449,047	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	77	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 77	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	7,651	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,651	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,953,068	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,402,370	31
32	Health Care	2,951,638	32
33	General Administration	1,755,937	33
	B. Capital Expense		
34	Ownership	1,428,519	34
	C. Ancillary Expense		
35	Special Cost Centers	1,212,921	35
36	Provider Participation Fee	209,938	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,961,323	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,008,255)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,008,255)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,289,058	44
45	Private Pay - Net Inpatient Revenue	1,664,026	45
46	Medicare - Net Inpatient Revenue	774,734	46
47	Other-(specify) Managed Care	71,042	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,798,860	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	1,552	1,656	$ 68,485	$ 41.36	1
2	Assistant Director of Nursing	2,049	2,815	68,044	24.17	2
3	Registered Nurses	34,173	36,729	1,049,808	28.58	3
4	Licensed Practical Nurses	11,035	11,572	251,861	21.76	4
5	CNAs & Orderlies	70,109	74,242	909,127	12.25	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,538	3,815	74,944	19.64	8
9	Activity Director	2,313	2,550	38,804	15.22	9
10	Activity Assistants	3,513	3,723	34,225	9.19	10
11	Social Service Workers	4,235	4,414	73,953	16.75	11
12	Dietician					12
13	Food Service Supervisor	215	222	2,983	13.44	13
14	Head Cook					14
15	Cook Helpers/Assistants	1,895	2,311	22,474	9.72	15
16	Dishwashers					16
17	Maintenance Workers	2,317	2,517	40,247	15.99	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,080	2,232	113,020	50.64	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,905	9,600	109,058	11.36	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	2,953	3,148	39,317	12.49	31
32	Other Health Care(specify)					32
33	Other(specify)	3,916	4,218	91,586	21.71	33
34	TOTAL (lines 1 - 33)	154,798	165,764	$ 2,987,936 *	$ 18.03	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	15	$ 752	01-03	35
36	Medical Director	Monthly	2,581	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,918	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	2,060	11-03	44
45	Social Service Consultant	Monthly	2,700	12-03	45
46	Other(specify)				46
47	Outsourced - Dietary	Monthly	359,594	01-03	47
48					48
49	TOTAL (lines 35 - 48)	15	$ 375,605		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	578	$ 30,592	10-03	50
51	Licensed Practical Nurses	340	16,642	10-03	51
52	Certified Nurse Assistants/Aides	769	19,960	10-03	52
53	TOTAL (lines 50 - 52)	1,687	$ 67,194		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ivy Gleeson	Administrator	0	$ 113,020
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 113,020

B. Administrative - Other

Description	Amount
Volume Admin Fee - Midwest Admin Services	$ 199,466
Base Management Fee - Bravo Nursing Home Services	138,000
Base Admin Fee - Midwest Admin Services	36,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 373,466
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Claims Administration Services	Related Party Legal (p. 6D)	$ 41,210
Infinite Solutions	IT Support	18,443
Larry Templin	Accounting	1,833
See Attached	Legal Fees	5,796
Kelly, Olson, Michod, DeHaan	Tax Assessment	65
Midwest Litigation Services	Court Reporter	1,206
Westlaw	Reference Software	1,336
Marcum	Accounting	1,466
Retirement Plan Associates	401K Consultant	88
Odessa Healthcare	Operations Consultant	35,718
Various	Other Professional	5,830
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 112,991

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 78,152
Unemployment Compensation Insurance	30,874
FICA Taxes	226,214
Employee Health Insurance	33,786
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K Expense	3,794
Employee Relations	2,096
Employee Physicals & Drug Tests	2,800
TOTAL (agree to Schedule V, line 22, col.8)	$ 377,715

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	9,263
Health Care Worker Background Check	
(Indicate # of checks performed 321)	3,214
Patient Background Checks	
Dues & Subscriptions	5,160
Allocated from MAS	2,096
Allocated from Bravo Nursing Home	2
Allocated from Bravo Holding Company	219
See Supplemental Schedule	151
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,104

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,655
Allocated from MAS	430
Allocated from Bravo Nursing Home	152
See Supplemental Schedule	299
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,536

* 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 $6,239**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **58,350** 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 fo
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 Departmen
during this cost report period. $ **209,938**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **1,291**

(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 fo
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
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