FOR BHF USE

LL1

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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.

I. IDPH License ID Number: 0049130

Facility Name: Rosewood Care Center Of Joliet

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

County: Will

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

HFS ID Number:

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

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda **Telephone Number:** (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/17 to 06/30/18 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, 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	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	4,224	9,837	10,856	24,917	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,224	9,837	10,856	24,917	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 56.89%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 11/01/07

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 58 and days of care provided 4,253

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: 6/30/2018 Fiscal Year: 6/30/2018

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

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			406,499	406,499		406,499		406,499			1
2	Food Purchase		177,997		177,997		177,997	(1,347)	176,650			2
3	Housekeeping		19,441	181,258	200,699		200,699		200,699			3
4	Laundry			120,839	120,839		120,839		120,839			4
5	Heat and Other Utilities			152,906	152,906		152,906	(11,278)	141,628			5
6	Maintenance	30,464	6,292	294,445	331,201		331,201	(42,777)	288,424			6
7	Other (specify):*							4,453	4,453			7
8	**TOTAL General Services**	30,464	203,730	1,155,947	1,390,141		1,390,141	(50,949)	1,339,192			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	2,236,032	221,201	7,334	2,464,567		2,464,567	26,459	2,491,026			10
10a	Therapy	109,844	1,111		110,955		110,955		110,955			10a
11	Activities	76,592	4,737	284	81,613		81,613		81,613			11
12	Social Services	72,362	245	2,500	75,107		75,107		75,107			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							2,691	2,691			15
16	**TOTAL Health Care and Programs**	2,494,830	227,294	28,118	2,750,242		2,750,242	29,150	2,779,392			16
	C. General Administration											
17	Administrative	98,218		337,072	435,290		435,290	(306,774)	128,516			17
18	Directors Fees											18
19	Professional Services			79,110	79,110		79,110	(11,320)	67,790			19
20	Dues, Fees, Subscriptions & Promotions			17,935	17,935		17,935	(114)	17,821			20
21	Clerical & General Office Expenses	80,911	23,314	392,839	497,064		497,064	(266,990)	230,074			21
22	Employee Benefits & Payroll Taxes			392,383	392,383		392,383		392,383			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,180	4,180		4,180	317	4,497			24
25	Other Admin. Staff Transportation			3,565	3,565		3,565	11,018	14,583			25
26	Insurance-Prop.Liab.Malpractice			96,112	96,112		96,112	12,078	108,190			26
27	Other (specify):*							22,305	22,305			27
28	**TOTAL General Administration**	179,129	23,314	1,323,196	1,525,639		1,525,639	(539,480)	986,159			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,704,423	454,338	2,507,261	5,666,022		5,666,022	(561,279)	5,104,743			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Rosewood Care Center Of Joliet #0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

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			7,009	7,009		7,009	150,127	157,136			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			100,971	100,971		100,971	165,644	266,615			32
33	Real Estate Taxes							110,083	110,083			33
34	Rent-Facility & Grounds			1,174,592	1,174,592		1,174,592	(1,158,236)	16,356			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			21,268	21,268		21,268	29,138	50,406			36
37	**TOTAL Ownership**			1,303,840	1,303,840		1,303,840	(703,244)	600,596			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		368,716	600,072	968,788		968,788		968,788			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			192,998	192,998		192,998		192,998			42
43	Other (specify):*	59,641		3,376	63,017		63,017	(63,017)	0			43
44	**TOTAL Special Cost Centers**	59,641	368,716	796,446	1,224,803		1,224,803	(63,017)	1,161,786			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,764,064	823,054	4,607,547	8,194,665		8,194,665	(1,327,540)	6,867,125			45

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

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	(644)	02		4
5	Telephone, TV & Radio in Resident Rooms	(11,715)	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	4,145	30		9
10	Interest and Other Investment Income	(278,697)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(703)	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	(8,143)	21		18
19	Entertainment	(37)	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	(332,113)	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				28
29	Other-Attach Schedule	(139,674)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (767,581)		$	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)	(559,959)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (559,959)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,327,540)		37

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

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

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

Rosewood Care Center Of Joliet

ID# 0049130

Report Period Beginning: 07/01/17

Ending: 06/30/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Additional R&M (Building Company)	$ 2,242	06	1
2	Non-Allowable Travel	(182)	25	2
3	Marketing Salary	(59,641)	43	3
4	Marketing Expense	(3,376)	43	4
5	Bank Charges	(3,079)	21	5
6	Vendor Discount	(4,509)	21	6
7	Miscellaneous Income	(372)	21	7
8	Midcap Line of Credit Fees	(21,268)	36	8
9	Vendor Late Charges	(12,066)	21	9
10	PAC Dues	(2,673)	20	10
11	Non-Allowable Legal	(830)	19	11
12	Bldg Co - Audit Fees	(7,290)	19	12
13	Bldg Co - Bank Charges	(13,930)	21	13
14	Bldg Co - Amortization Loan Fee	(4,756)	36	14
15	Capitalized R&M	(7,944)	06	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**	(139,674)		49

Rosewood Care Center Of Joliet

ID# 0049130

Report Period Beginning: 07/01/17

Ending: 06/30/18

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

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													1
2	Food Purchase	(1,347)											(1,347)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(11,715)					200	237					(11,278)	5
6	Maintenance	(5,702)					58	(37,132)					(42,777)	6
7	Other (specify):*							4,453					4,453	7
8	**TOTAL General Services**	(18,764)					257	(32,443)					(50,949)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				26,459								26,459	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				2,691								2,691	15
16	**TOTAL Health Care and Programs**				29,150								29,150	16
	C. General Administration													
17	Administrative			11,181	(118,884)		(199,072)						(306,774)	17
18	Directors Fees													18
19	Professional Services	(8,120)	7,290	15,438	285	(26,212)							(11,320)	19
20	Fees, Subscriptions & Promotions	(2,673)			7	190	2,338	24					(114)	20
21	Clerical & General Office Expenses	(374,249)	19,330		493	18,867	68,085	484					(266,990)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar				50	141	126						317	24
25	Other Admin. Staff Transportation	(182)			3,211	593	4,951	2,446					11,018	25
26	Insurance-Prop.Liab.Malpractice		7,350				3,780	948					12,078	26
27	Other (specify):*				1,730	1,987	18,587						22,305	27
28	**TOTAL General Administration**	(385,224)	33,970	26,619	(113,108)	(4,434)	(101,205)	3,901					(539,480)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(403,988)	33,970	26,619	(83,957)	(4,434)	(100,947)	(28,541)					(561,279)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 **Report Period Beginning:** 07/01/17 **Ending:** 06/30/18

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	4,145	138,710				7,043	228					150,127	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(278,697)	432,547	(903)			12,697						165,644	32
33	Real Estate Taxes		110,083										110,083	33
34	Rent-Facility & Grounds		(1,171,367)				13,131						(1,158,236)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*	(26,024)	55,162										29,138	36
37	**TOTAL Ownership**	(300,576)	(434,866)	(903)			32,872	228					(703,244)	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):*	(63,017)											(63,017)	43
44	**TOTAL Special Cost Centers**	(63,017)											(63,017)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(767,581)	(400,895)	25,716	(83,957)	(4,434)	(68,075)	(28,313)					(1,327,540)	45

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

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	$ 1,171,367	Joliet Real Estate Holding, LLC	100.00%	$	$ (1,171,367)	1
2	V	19	Audit Fees		Joliet Real Estate Holding, LLC	100.00%	7,290	7,290	2
3	V	21	Bank Charges		Joliet Real Estate Holding, LLC	100.00%	13,930	13,930	3
4	V	32	Interest Expense - HUD Mortgage		Joliet Real Estate Holding, LLC	100.00%	432,547	432,547	4
5	V	36	Interest Expense - HUD MIP		Joliet Real Estate Holding, LLC	100.00%	50,405	50,405	5
6	V	33	Real Estate Tax		Joliet Real Estate Holding, LLC	100.00%	110,083	110,083	6
7	V	30	Depreciation		Joliet Real Estate Holding, LLC	100.00%	138,710	138,710	7
8	V	36	Amortization Loan Fee		Joliet Real Estate Holding, LLC	100.00%	4,756	4,756	8
9	V	21	Base Admin Fee (Page 6D)		Joliet Real Estate Holding, LLC	100.00%	5,400	5,400	9
10	V	26	Insurance Expense - Property		Joliet Real Estate Holding, LLC	100.00%	7,350	7,350	10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,171,367			$ 770,472	$ * (400,895)	14

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

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%	$ 11,181	$ 11,181	15
16	V	19	PROFESSIONAL FEES		BRAVO HOLDING COMPANY	100.00%	15,438	15,438	16
17	V	32	INTEREST		BRAVO HOLDING COMPANY	100.00%	(903)	(903)	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			$			$ 25,716	$ * 25,716	39

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

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	10	CORPORATE RN SALARIES	$	BRAVO NURSING HOME SERVICES, INC.	100.00%	$ 26,459	$ 26,459	15
16	V	15	CORPORATE RN SALARIES BENEFITS		BRAVO NURSING HOME SERVICES, INC.	100.00%	2,691	2,691	16
17	V	17	ADMINISTRATIVE SALARIES		BRAVO NURSING HOME SERVICES, INC.	100.00%	19,116	19,116	17
18	V	19	PROFESSIONAL FEES		BRAVO NURSING HOME SERVICES, INC.	100.00%	285	285	18
19	V	20	DUES & SUBSCRIPTIONS		BRAVO NURSING HOME SERVICES, INC.	100.00%	7	7	19
20	V	21	OFFICE EXPENSES		BRAVO NURSING HOME SERVICES, INC.	100.00%	493	493	20
21	V	24	SEMINAR & LODGING EXPENSE		BRAVO NURSING HOME SERVICES, INC.	100.00%	50	50	21
22	V	25	AUTO EXPENSE		BRAVO NURSING HOME SERVICES, INC.	100.00%	3,211	3,211	22
23	V	27	ADMINISTRATIVE & OFFICE BENEFITS		BRAVO NURSING HOME SERVICES, INC.	100.00%	1,730	1,730	23
24	V								24
25	V								25
26	V	17	ADMINISTRATIVE FEE	138,000	BRAVO NURSING HOME SERVICES, INC.	100.00%		(138,000)	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			$ 138,000			$ 54,043	$ * (83,957)	39

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

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%	$ 845	$ 845	15
16	V	20	LICENSES		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	190	190	16
17	V	21	LEGAL SALARIES		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	17,992	17,992	17
18	V	21	OFFICE EXPENSE		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	876	876	18
19	V	24	SEMINAR		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	141	141	19
20	V	25	AUTO / TRAVEL EXPENSE		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	593	593	20
21	V	27	EMPLOYEE BENEFITS		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	1,987	1,987	21
22	V								22
23	V	19	PROFESSIONAL FEES	27,057	CLAIMS ADMINISTRATION SERVICES, LLC	100.00%		(27,057)	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 27,057			$ 22,623	$ * (4,434)	39

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

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%	$ 200	$ 200	15
16	V	6	MAINTENANCE EXPENSE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	58	58	16
17	V	20	DUES, SUBSCRIPTIONS, LICENSES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	2,338	2,338	17
18	V	21	OFFICE SALARIES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	58,809	58,809	18
19	V	21	OFFICE EXPENSES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	14,676	14,676	19
20	V	24	SEMINAR		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	126	126	20
21	V	25	TRAVEL EXPENSE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	4,951	4,951	21
22	V	26	INSURANCE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	3,780	3,780	22
23	V	27	EMPLOYEE BENEFITS		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	18,587	18,587	23
24	V	30	DEPRECIATION		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	7,043	7,043	24
25	V	32	INTEREST		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	12,697	12,697	25
26	V	34	BUILDING RENT		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	13,131	13,131	26
27	V								27
28	V								28
29	V	17	ADMINISTRATIVE FEE	199,072	MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%		(199,072)	29
30	V	21	ADMINISTRATIVE FEE (BLDG CO)	5,400	MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%		(5,400)	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			$ 204,472			$ 136,397	$ * (68,075)	39

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	SENIOR LIVING SERVICES, INC.	100.00%	$ 237	$ 237	15
16	V	6	MAINTENANCE SALARY		SENIOR LIVING SERVICES, INC.	100.00%	31,807	31,807	16
17	V	6	MAINTENANCE EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	3,340	3,340	17
18	V	7	MAINTENANCE BENEFITS		SENIOR LIVING SERVICES, INC.	100.00%	4,453	4,453	18
19	V	20	LICENSES		SENIOR LIVING SERVICES, INC.	100.00%	24	24	19
20	V	21	OFFICE EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	484	484	20
21	V	25	AUTO / TRAVEL EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	2,446	2,446	21
22	V	26	INSURANCE		SENIOR LIVING SERVICES, INC.	100.00%	948	948	22
23	V	30	DEPRECIATION		SENIOR LIVING SERVICES, INC.	100.00%	228	228	23
24	V								24
25	V	6	MAINTENANCE SERVICES	72,719	SENIOR LIVING SERVICES, INC.	100.00%	439	(72,280)	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			$ 72,719			$ 44,406	$ * (28,313)	39

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Hinde Feiner	50.00%	Bravo Care of Alton, Inc.	Alton, IL	Joliet Real Estate Holding, LLC	Joliet, IL	Lessor	1
2	Hillel Yampol	50.00%	Bravo Care of East Peoria, Inc.	East Peoria, IL	Bravo Administrative Services, Inc.	St. Louis, MO	Administration	2
3			Bravo Care of Edwardsville, Inc.	Edwardsville, IL	Bravo Holding Company, Inc.	St. Louis, MO	Holding Company	3
4			Bravo Care of Elgin, Inc.	Elgin, IL	Bravo Nursing Home Services, Inc.	St. Louis, MO	Management	4
5			Bravo Care of Galesburg, Inc.	Galesburg, IL	Bravo Team Health, Inc.	St. Louis, MO	Human Resources	5
6			Bravo Care of Inverness, Inc.	Inverness, IL	Claims Administration Services, LL	St. Louis, MO	Legal Services	6
7			Bravo Care of Moline, Inc.	Moline, IL	Senior Living Services, Inc.	St. Louis, MO	Building Services	7
8			Bravo Care of Northbrook, Inc.	Northbrook, IL	Midwest Administrative Services, I	St. Louis, MO	Administration	8
9			Bravo Care of Peoria, Inc.	Peoria, IL	Bravo Care of Wood River, Inc.	Wood River, IL	Supportive Living Facility	9
10			Bravo Care of Rockford, Inc.	Rockford, IL	Rosewood Home Health Services, I	Edwardsville, IL	Home Health	10
11			Bravo Care of St. Charles, Inc.	St. Charles, IL				11
12			Bravo Care of St. Louis, Inc.	St. Louis, MO				12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

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	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

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	445,689	14	$ 200,000	$	24,917	$ 11,181	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	445,689	14	276,131		24,917	15,438	2
3	32	INTEREST	PATIENT DAYS	445,689	14	(16,156)		24,917	(903)	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					$ 459,975	$		$ 25,716	25

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

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	10	CORPORATE RN SALARIES	PAT. DAYS	445,689	14	$ 473,276	$ 473,276	24,917	$ 26,459	1
2	15	CORPORATE RN SALARIES BE	PAT. DAYS	445,689	14	48,136		24,917	2,691	2
3	17	ADMINISTRATIVE SALARIES	PAT. DAYS	445,689	14	341,934	341,934	24,917	19,116	3
4	19	PROFESSIONAL FEES	PAT. DAYS	445,689	14	5,100		24,917	285	4
5	20	DUES & SUBSCRIPTIONS	PAT. DAYS	445,689	14	121		24,917	7	5
6	21	OFFICE EXPENSES	PAT. DAYS	445,689	14	8,815		24,917	493	6
7	24	SEMINAR & LODGING EXPEN	PAT. DAYS	445,689	14	888		24,917	50	7
8	25	AUTO EXPENSE	PAT. DAYS	445,689	14	57,444		24,917	3,211	8
9	27	ADMINISTRATIVE & OFFICE I	PAT. DAYS	445,689	14	30,948		24,917	1,730	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					$ 966,663	$ 815,210		$ 54,043	25

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

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	307,124	14	$ 9,587	$	27,057	$ 845	1
2	20	LICENSES	ACTUAL FEES	307,124	14	2,155		27,057	190	2
3	21	LEGAL SALARIES	ACTUAL FEES	307,124	14	204,221	204,221	27,057	17,992	3
4	21	OFFICE EXPENSE	ACTUAL FEES	307,124	14	9,942		27,057	876	4
5	24	SEMINAR	ACTUAL FEES	307,124	14	1,603		27,057	141	5
6	25	AUTO / TRAVEL EXPENSE	ACTUAL FEES	307,124	14	6,726		27,057	593	6
7	27	EMPLOYEE BENEFITS	ACTUAL FEES	307,124	14	22,559		27,057	1,987	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					$ 256,792	$ 204,221		$ 22,623	25

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

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	445,689	14	$ 3,576	$	24,917	$ 200	1
2	6	MAINTENANCE EXPENSE	PAT. DAYS	445,689	14	1,030		24,917	58	2
3	20	DUES, SUBSCRIPTIONS, LICEN	PAT. DAYS	445,689	14	41,819		24,917	2,338	3
4	21	OFFICE SALARIES	PAT. DAYS	445,689	14	1,051,919	1,051,919	24,917	58,809	4
5	21	OFFICE EXPENSES	PAT. DAYS	445,689	14	262,500		24,917	14,676	5
6	24	SEMINAR	PAT. DAYS	445,689	14	2,257		24,917	126	6
7	25	TRAVEL EXPENSE	PAT. DAYS	445,689	14	88,555		24,917	4,951	7
8	26	INSURANCE	PAT. DAYS	445,689	14	67,605		24,917	3,780	8
9	27	EMPLOYEE BENEFITS	PAT. DAYS	445,689	14	332,469		24,917	18,587	9
10	30	DEPRECIATION	PAT. DAYS	445,689	14	125,986		24,917	7,043	10
11	32	INTEREST	PAT. DAYS	445,689	14	227,119		24,917	12,697	11
12	34	BUILDING RENT	PAT. DAYS	445,689	14	234,875		24,917	13,131	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,439,709	$ 1,051,919		$ 136,397	25

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

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	1,015,133	14	$ 3,306	$	72,719	$ 237	1
2	6	MAINTENANCE SALARY	ACTUAL FEES	1,015,133	14	444,019	444,019	72,719	31,807	2
3	6	MAINTENANCE EXPENSE	ACTUAL FEES	1,015,133	14	46,631		72,719	3,340	3
4	7	MAINTENANCE BENEFITS	ACTUAL FEES	1,015,133	14	62,159		72,719	4,453	4
5	20	LICENSES	ACTUAL FEES	1,015,133	14	332		72,719	24	5
6	21	OFFICE EXPENSE	ACTUAL FEES	1,015,133	14	6,751		72,719	484	6
7	25	AUTO / TRAVEL EXPENSE	ACTUAL FEES	1,015,133	14	34,139		72,719	2,446	7
8	26	INSURANCE	ACTUAL FEES	1,015,133	14	13,240		72,719	948	8
9	30	DEPRECIATION	ACTUAL FEES	1,015,133	14	3,189		72,719	228	9
10										10
11	6	MAINTENANCE SERVICES	DIRECT ALLOCATION		14	4,891			439	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					$ 618,657	$ 444,019		$ 44,406	25

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Berkadia		X	Mortgage	$91,297.26	4/1/04	$ 14,104,500	$ 12,122,796	5/1/39	0.0450	$ 432,547	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Midcap		X	Revolving Line of Credit							100,971	6
7												7
8												8
9	TOTAL Facility Related				$91,297.26		$ 14,104,500	$ 12,122,796			$ 533,518	9
	B. Non-Facility Related*											
10	Interest Income		X								(278,697)	10
11	Alloc from Bravo Holding Co		X								(903)	11
12	Alloc from Midwest Admin Services		X								12,697	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (266,903)	14
15	TOTALS (line 9+line14)						$ 14,104,500	$ 12,122,796			$ 266,616	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 50,405 Line # 36

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

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 128,566	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.)		$ 110,270	2
3. Under or (over) accrual (line 2 minus line 1).		$ (18,297)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 182,659	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.		$ 164,363	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	116,736	8
	2014	118,435	9
	2015	117,736	10
	2016	111,980	11
	2017	108,559	12

Accrual based on PY tax bill.

RE Taxes on Line 2 are the second installment of the 2016 tax bill and the first installment of the 2017 tax bill.

The variance of $54,280 between line 7 above and line 33 on page 4, is the amount of the first installment of the 2017 bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rosewood Care Center Of Joliet COUNTY Will

FACILITY IDPH LICENSE NUMBER 0049130

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-03-26-203-123-0000	Nursing Home	$ 108,559.12	$ 108,559.12
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 108,559.12	$ 108,559.12

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 2017 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 2017 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2017.

Please complete the Real Estate Tax Statement below and include it in the 2018 cost report along with a copy of your 2017 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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rosewood Care Center Of Joliet COUNTY Will

FACILITY IDPH LICENSE NUMBER 0049130

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

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

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

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		1990	1990	$ 3,475,917	$ 138,710	40	$ 86,898	$ (51,812)	$ 2,433,142	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2013	5,785		20	826	826	4,200	9
10	Various			2014	10,570		20	1,510	1,510	6,351	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

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)		946,446			34,859	34,859	773,884	67
68	Related Party Allocations (Pages 12H & 12I)		281	56		56		112	68
69	Financial Statement Depreciation			7,009			(7,009)		69
70	TOTAL (lines 4 thru 69)		$ 4,438,999	$ 145,775		$ 124,149	$ (21,626)	$ 3,217,689	70

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

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		$ 4,438,999	$ 145,775		$ 124,149	$ (21,626)	$ 3,217,689	1
2	Generator Repair	2015	3,850		20	193	193	578	2
3	Remove Old Piping/Install New - Rm 409, Reset Dry Valve	2015	5,035		20	252	252	756	3
4	New Accelerator Installation, Replaced 4" Dry Valve	2016	6,855		20	343	343	1,028	4
5	Generator Drip Repair	2017	2,513		20	126	126	126	5
6	Boiler Pump Repair	2018	2,689		20	134	134	134	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16	Continued from 12G-Building Company-Leasehold Improvements								16
17									17
18	Hot Water Heater	2016	7,985		20	399	399	798	18
19	Water Heater	2016	6,846		20	342	342	684	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)		$ 4,474,772	$ 145,775		$ 125,937	$ (19,837)	$ 3,221,793	34

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

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		$ 4,474,772	$ 145,775		$ 125,937	$ (19,837)	$ 3,221,793	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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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)		$ 4,474,772	$ 145,775		$ 125,937	$ (19,837)	$ 3,221,793	34

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

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		$ 4,474,772	$ 145,775		$ 125,937	$ (19,837)	$ 3,221,793	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)		$ 4,474,772	$ 145,775		$ 125,937	$ (19,837)	$ 3,221,793	34

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

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		$ 4,474,772	$ 145,775		$ 125,937	$ (19,837)	$ 3,221,793	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)		$ 4,474,772	$ 145,775		$ 125,937	$ (19,837)	$ 3,221,793	34

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Storm Sewer	1991	32,675		25			32,675	9
10	Lawn Sprinkler	1991	13,190		25			13,190	10
11	Landscaping	1991	60,077		25			60,077	11
12	Mass Grading	1991	54,747		25			54,747	12
13	Asphalt Paving	1991	48,390		25			48,390	13
14	Sanitary Sewer	1991	8,069		25			8,069	14
15	Water Line	1991	15,500		25			15,500	15
16	Driveway & Sidewalks	1991	55,932		25			55,932	16
17	Walk-In Cooler Refrigeration	1991	6,888		10			6,888	17
18	Exhaust & Air Hood	1991	4,670		10			4,670	18
19	Generator Accessories	1991	15,764		10			15,764	19
20	6 Stainless Doors	1991	2,685		10			2,685	20
21	Monument Sign	1991	3,193		10			3,193	21
22	Nurse Call Station	1991	28,217		10			28,217	22
23	Fire Alarm System	1991	15,724		10			15,724	23
24	Door Alarm	1991	5,773		10			5,773	24
25	Public Address	1991	5,022		10			5,022	25
26	Hot Water Boiler	1991	6,792		10			6,792	26
27	Hot Watter Heater	1991	7,841		10			7,841	27
28	Seal & Stripe New Parking Spaces	2003	11,439		25	458	458	6,751	28
29	Roof Replacement	2005	6,944		40	174	174	2,273	29
30	Water Softener	2005	5,116		10			5,116	30
31	Door Closers	2005	5,496		10			5,496	31
32	Patient Rooms Sinks	2006	23,683		10			23,683	32
33	Satellite System	2006	9,002		10			9,002	33
34	TOTAL (lines 1 thru 33)		$ 452,829	$		$ 631	$ 631	$ 443,470	34

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 452,829	$		$ 631	$ 631	$ 443,470	1
2	Seal & Patch Parking Lot	2006	5,055		25	202	202	2,358	2
3	Heat Pumps	2007	3,004		10	77	77	3,004	3
4	Nurse Call System	2008	71,367		10	4,346	4,346	71,367	4
5	Fire Alarm System	2008	54,919		10	3,038	3,038	54,919	5
6	Carpet	2008	4,579		10	419	419	4,579	6
7	Fire Alarm System	2008	6,381		10	638	638	6,381	7
8	Nurse Call System	2008	14,550		10	1,455	1,455	14,429	8
9	Telephone System	2008	22,919		10	1,718	1,718	22,919	9
10	Concrete Pad for Dumpster	2009	4,350		10	435	435	3,951	10
11	Grease Trap	2009	6,115		10	612	612	5,709	11
12	Sprinkler System Pipe	2009	3,715		10	372	372	3,315	12
13	Parking Lot Seal & Stripe	2009	11,518		25	461	461	4,122	13
14	Cooling Tower	2010	88,905		10	8,891	8,891	73,349	14
15	Sprinkler Pipe	2010	11,181		10	1,118	1,118	9,224	15
16	Cooling Tower Addition	2010	1,350		10	135	135	1,080	16
17	Sprinkler	2010	3,884		10	388	388	2,976	17
18	Paving / Concrete	2012	52,000		25	2,080	2,080	12,081	18
19	Cooling Tower Starter	2012	3,178		10	318	318	1,855	19
20	HVAC	2012	3,359		40	84	84	504	20
21	Exit Doors 1, 8, and 10, and Beverage Room Door	2013	8,675		40	217	217	1,157	21
22	Sprinkler Repairs	2013	10,441		40	261	261	1,370	22
23	Architectural Fee	2013	8,273		40	207	207	1,000	23
24	Engineering & Surveying	2013	7,600		25	304	304	1,464	24
25	Doors	2014	9,061		40	227	227	1,014	25
26	HVAC Improvements	2014	45,798		10	4,580	4,580	20,610	26
27	Seal Coating	2014	4,200		25	168	168	672	27
28	Asphalt Repair	2014	4,425		25	177	177	664	28
29	Parking Lot Light	2014	3,660		25	146	146	548	29
30	Electric Power Feeds - Baseboard Heaters in Dining Room	2014	3,485		10	349	349	1,279	30
31	Sewer Stoppage / Plumbing Repairs	2014	6,477		40	162	162	607	31
32	Walk-In Cooler	2015	6,393		10	533	533	1,599	32
33	Repaired Concrete Curb	2015	2,800		25	112	112	308	33
34	TOTAL (lines 1 thru 33)		$ 946,446	$		$ 34,859	$	$ 773,884	34

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

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	Allocated from Senior Living Services	2017	281	56	20	56		112	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)		$ 281	$ 56		$ 56	$	$ 112	34

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

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		$ 281	$ 56		$ 56	$	$ 112	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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16									16
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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)		$ 281	$ 56		$ 56	$	$ 112	34

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

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	$ 343,282	$ 1,839	$ 25,547	$ 23,708	10	$ 322,069	71
72	Current Year Purchases	2,742		274	274	10	274	72
73	Fully Depreciated Assets	14,958	134	134		10	14,958	73
74								74
75	TOTALS	$ 360,982	$ 1,973	$ 25,955	$ 23,982		$ 337,301	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	$ 37,516	$ 5,070	$ 5,070	$ 0	5	$ 35,951	76
77		Allocated from Senior Living Ser	2016	10,722	172	172	0	5	10,722	77
78										78
79										79
80	TOTALS			$ 48,239	$ 5,242	$ 5,242	$ 0		$ 46,674	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,097,772	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 152,990	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 157,135	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 4,145	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,605,767	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Off-Site Storage				3,225			5
6	Allocated from Midwest Administrative Services, Inc.				13,131			6
7	TOTAL				$ 16,356 **			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.	/2019	$
13.	/2020	$
14.	/2021	$

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			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

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	$		$ 214,970	$		$ 214,970	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			80,182			80,182	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			281,467			281,467	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				338,429		338,429	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					23,453	30,287		53,740	13
14	TOTAL			$		$ 600,072	$ 368,716		$ 968,788	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Rosewood Care Center Of Joliet # 0049130 Report Period Beginning: 07/01/17 Ending: 06/30/18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/18 (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	$ 500	$ 500	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,926,269	1,926,269	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	48,023	52,601	6
7	Other Prepaid Expenses		233,840	7
8	Accounts Receivable (owners or related parties)	5,841,017	5,841,017	8
9	Other(specify): See Attached Schedule	2,000	12,000	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 7,817,809	$ 8,066,227	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		213,780	13
14	Buildings, at Historical Cost		3,690,247	14
15	Leasehold Improvements, at Historical Cost	16,355	407,632	15
16	Equipment, at Historical Cost	54,849	848,757	16
17	Accumulated Depreciation (book methods)	(65,372)	(3,590,974)	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):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,832	$ 1,569,442	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,823,641	$ 9,635,669	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,081,340	$ 4,771,688	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	175,293	175,293	30
31	Accrued Taxes Payable (excluding real estate taxes)	282,376	282,376	31
32	Accrued Real Estate Taxes(Sch.IX-B)		182,659	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes		20,790	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	4,552,839	451,485	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 8,091,848	$ 5,884,291	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		12,122,796	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 12,122,796	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,091,848	$ 18,007,087	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (268,207)	$ (8,371,418)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,823,641	$ 9,635,669	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 977,408	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 977,407	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,245,614)	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)**	$ (1,245,614)	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)**	$ (268,207)	24 *

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

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,502,321	1
2	Discounts and Allowances for all Levels	(1,852,658)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,649,663	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,527,110	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,527,110	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,125	13
14	Non-Patient Meals	644	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	335,352	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	53,991	19
20	Radiology and X-Ray	20,917	20
21	Other Medical Services	76,671	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 488,700	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	278,697	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 278,697	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	4,881	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,881	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,949,051	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,390,141	31
32	Health Care	2,750,242	32
33	General Administration	1,525,639	33
	B. Capital Expense		
34	Ownership	1,303,840	34
	C. Ancillary Expense		
35	Special Cost Centers	1,031,805	35
36	Provider Participation Fee	192,998	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,194,665	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,245,614)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,245,614)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,612,984	44
45	Private Pay - Net Inpatient Revenue	1,937,918	45
46	Medicare - Net Inpatient Revenue	823,366	46
47	Other-(specify) Insurance/Managed Care	275,395	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,649,663	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,212	2,212	$ 90,965	$ 41.12	1
2	Assistant Director of Nursing	2,123	2,123	74,788	35.23	2
3	Registered Nurses	30,747	32,543	1,009,309	31.01	3
4	Licensed Practical Nurses	9,698	9,900	239,375	24.18	4
5	CNAs & Orderlies	56,985	58,336	789,698	13.54	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,699	7,037	109,844	15.61	8
9	Activity Director	2,173	2,173	48,210	22.19	9
10	Activity Assistants	3,071	3,071	28,382	9.24	10
11	Social Service Workers	2,434	4,307	72,362	16.80	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	2,286	2,331	30,464	13.07	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,037	2,037	98,218	48.22	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,526	6,645	80,911	12.18	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	1,943	2,090	31,897	15.26	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	2,547	2,641	59,641	22.58	33
34	TOTAL (lines 1 - 33)	131,481	137,446	$ 2,764,064 *	$ 20.11	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		$		35
36	Medical Director	Monthly	18,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,334	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	284	11-03	44
45	Social Service Consultant	Monthly	2,500	12-03	45
46	Other(specify)				46
47	Outsourced Dietary	Monthly	406,499	01-03	47
48					48
49	TOTAL (lines 35 - 48)		$ 434,617		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
William Matjasich	Administrator	0	$ 98,218
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 98,218

B. Administrative - Other

Description	Amount
Base Management Fee - Bravo Nursing Home Services	$ 138,000
Base Admin Fee - Midwest Admin Services	36,000
Volume Admin Fee - Midwest Admin Services	163,072
TOTAL (agree to Schedule V, line 17, col. 3)	$ 337,072
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 9,219
Ability Network Inc	Data Processing	4,578
Infinite Solutions	IT Solution Provider	21,846
Resolute Healthcare Solutions	Business Operations Mngmt	3,171
Claims Administrative Services	Claims Management	27,057
Legal Fees	See Attached	13,239
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 79,110

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 88,406
Unemployment Compensation Insurance	29,312
FICA Taxes	207,552
Employee Health Insurance	53,925
Employee Meals	868
Illinois Municipal Retirement Fund (IMRF)*	
401K Expense	5,626
Dental Insurance	1,745
Employee Drug Tests	624
Employee Physicals & Vaccinations	2,030
Employee Relations	2,296
TOTAL (agree to Schedule V, line 22, col.8)	$ 392,384

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	1,682
Health Care Worker Background Check	
(Indicate # of checks performed 332	3,319
Patient Background Checks	
Dues & Subscriptions	6,281
Alloc from Bravo Nrsg Home Services	7
Alloc from Claims Admin Services	190
Alloc from Midwest Admin Services	2,338
Alloc from Senior Living Services	24
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,821

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,180
Alloc from Bravo Nrsg Home Services	50
Alloc from Midwest Admin Services	126
Alloc from Claims Admin Services	141
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,497

* Attach copy of IMRF notifications

**See instructions.

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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA - $8,894**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **47,801** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **192,998**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **868** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **644**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.