

Facility Name & ID Number Rosewood Care Ctr of Joliet

0049130 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	12	3,506	11,781	15,299	8
9	SNF/PED					9
10	ICF	9,849	10,367	48	20,264	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,861	13,873	11,829	35,563	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.19%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

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 Date 11/01/07 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 58 and days of care provided 9,502

Medicare Intermediary Novitas Solutions, Inc.

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 06/30/14 Fiscal Year: 06/30/14

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	237,020	20,496	14,848	272,364		272,364	1,740	274,104		1
2	Food Purchase		228,233		228,233		228,233	(6,420)	221,813		2
3	Housekeeping	149,870	47,834		197,704		197,704		197,704		3
4	Laundry	49,679	18,871		68,550		68,550		68,550		4
5	Heat and Other Utilities			152,631	152,631		152,631	227	152,858		5
6	Maintenance	26,861	10,937	243,490	281,288		281,288	(63,201)	218,087		6
7	Other (specify):* Allocated HO Benefits							4,652	4,652		7
8	TOTAL General Services	463,430	326,371	410,969	1,200,770		1,200,770	(63,002)	1,137,768		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	2,666,723	224,668	16,163	2,907,554		2,907,554	48,144	2,955,698		10
10a	Therapy		3,190	1,069,268	1,072,458		1,072,458		1,072,458		10a
11	Activities	79,986	5,406	799	86,191		86,191		86,191		11
12	Social Services	62,777		2,400	65,177		65,177		65,177		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Allocated HO Benefits							4,059	4,059		15
16	TOTAL Health Care and Programs	2,809,486	233,264	1,106,630	4,149,380		4,149,380	52,203	4,201,583		16
	C. General Administration										
17	Administrative	98,322		296,040	394,362		394,362	(279,101)	115,261		17
18	Directors Fees										18
19	Professional Services			313,328	313,328		313,328	27,422	340,750		19
20	Dues, Fees, Subscriptions & Promotions			20,244	20,244		20,244	(847)	19,397		20
21	Clerical & General Office Expenses	106,366	14,562	38,621	159,549		159,549	158,534	318,083		21
22	Employee Benefits & Payroll Taxes			468,289	468,289		468,289		468,289		22
23	Inservice Training & Education										23
24	Travel and Seminar			271	271		271	6,531	6,802		24
25	Other Admin. Staff Transportation			6,479	6,479		6,479	2,505	8,984		25
26	Insurance-Prop.Liab.Malpractice			85,927	85,927		85,927	40,219	126,146		26
27	Other (specify):* Allocated HO Benefits							15,126	15,126		27
28	TOTAL General Administration	204,688	14,562	1,229,199	1,448,449		1,448,449	(29,611)	1,418,838		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,477,604	574,197	2,746,798	6,798,599		6,798,599	(40,410)	6,758,189		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 Ctr of Joliet

#0049130

Report Period Beginning: 07/01/2013 Ending: 06/30/2014

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			17,374	17,374		17,374	92,561	109,935			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							287,556	287,556			32
33	Real Estate Taxes			56,055	56,055		56,055	65,328	121,383			33
34	Rent-Facility & Grounds			1,500,110	1,500,110		1,500,110	(669,382)	830,728			34
35	Rent-Equipment & Vehicles			22,235	22,235		22,235	10,379	32,614			35
36	Other (specify):*											36
37	TOTAL Ownership			1,595,774	1,595,774		1,595,774	(213,558)	1,382,216			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		498,337		498,337		498,337		498,337			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			216,976	216,976		216,976		216,976			42
43	Other (specify):* See Page 4A	96,973		212,485	309,458		309,458	(260,995)	48,463			43
44	TOTAL Special Cost Centers	96,973	498,337	429,461	1,024,771		1,024,771	(260,995)	763,776			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,574,577	1,072,534	4,772,033	9,419,144		9,419,144	(514,963)	8,904,181			45

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

Rosewood Care Ctr of Joliet

Period Beginning 07/01/2013

Period End 06/30/2014

Schedule 4A

V. Cost Center Expenses

		Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	Ancillary Expense										
	E. Special Cost Centers										
43	Other (specify):*				0		0		0		
	Laboratory Expense			13,985	13,985		13,985		13,985		
	Radiology Expenses			34,478	34,478		34,478		34,478		
	Non-Allowable Expenses	96,973		164,022	260,995		260,995	(260,995)	0		
					0		0		0		
					0		0		0		
	TOTAL Other Special Cost Centers	96,973	0	212,485	309,458	0	309,458	(260,995)	48,463		

Facility Name & ID Number Rosewood Care Ctr of Joliet

0049130

Report Period Beginning: 07/01/2013

Ending: 06/30/2014

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,788)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,780)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(15,353)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,662)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(2,637)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(26,384)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(146,708)	43		24
25	Fund Raising, Advertising and Promotional	(10,514)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	10,103	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		43		28
29	Other-Attach Schedule See Page 5A	(105,683)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (310,406)		\$	30

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	2	
		Amount	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)	(204,557)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (204,557)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (514,963)		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48		49		50	51
					52

Rosewood Care Ctr of Joliet

ID# 0049130

Report Period Beginning: 07/01/2013

Ending: 06/30/2014

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Eliminate Marketing Salary	\$ (96,973)	43	1
2	Miscellaneous Income Offset	(3,328)	21	2
3	Disallow Resident Reimbursement	(20)	43	3
4	Disallow Marketing Mileage Reimbursement	(5,362)	25	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				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		(105,683)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Ctr of Joliet# 0049130

Report Period Beginning:

07/01/2013

Ending:

06/30/2014

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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	1,740	0	0	0	0	0	0	0	0	1,740	1
2	Food Purchase	(6,450)	0	30	0	0	0	0	0	0	0	0	(6,420)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	204	0	23	0	0	0	0	0	0	227	5
6	Maintenance	0	0	152	0	(63,353)	0	0	0	0	0	0	(63,201)	6
7	Other (specify):*	0	0	197	0	4,455	0	0	0	0	0	0	4,652	7
8	TOTAL General Services	(6,450)	0	2,323	0	(58,875)	0	0	0	0	0	0	(63,002)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	43,713	4,431	0	0	0	0	0	0	0	0	48,144	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	3,559	500	0	0	0	0	0	0	0	0	4,059	15
16	TOTAL Health Care and Programs	0	47,272	4,931	0	0	0	0	0	0	0	0	52,203	16
	C. General Administration													
17	Administrative	0	(123,206)	(159,495)	0	0	3,600	0	0	0	0	0	(279,101)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(26,384)	111	8,491	(57,209)	0	100,165	2,248	0	0	0	0	27,422	19
20	Fees, Subscriptions & Promotions	(2,637)	11	1,499	271	9	0	0	0	0	0	0	(847)	20
21	Clerical & General Office Expenses	(3,328)	49,924	96,150	13,152	684	453	1,499	0	0	0	0	158,534	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,766	2,901	108	1,691	65	0	0	0	0	0	6,531	24
25	Other Admin. Staff Transportation	(5,362)	2,670	1,253	264	3,680	0	0	0	0	0	0	2,505	25
26	Insurance-Prop.Liab.Malpractice	0	304	1,991	138	1,060	489	36,237	0	0	0	0	40,219	26
27	Other (specify):*	0	5,185	8,686	1,255	0	0	0	0	0	0	0	15,126	27
28	TOTAL General Administration	(37,711)	(63,235)	(38,524)	(42,021)	7,124	101,172	43,584	0	0	0	0	(29,611)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(44,161)	(15,963)	(31,270)	(42,021)	(51,751)	101,172	43,584	0	0	0	0	(40,410)	29

STATE OF ILLINOIS

Facility Name & ID Number Rosewood Care Ctr of Joliet# 0049130

Report Period Beginning:

07/01/2013 Ending:

Summary B

06/30/2014

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	6,662	0	1,142	0	84,757	0	0	0	0	92,561	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(15,353)	0	479	68	0	16,824	285,538	0	0	0	0	287,556	32
33	Real Estate Taxes	0	0	0	0	0	0	65,328	0	0	0	0	65,328	33
34	Rent-Facility & Grounds	0	0	5,991	0	0	0	(675,373)	0	0	0	0	(669,382)	34
35	Rent-Equipment & Vehicles	0	9,148	1,231	0	0	0	0	0	0	0	0	10,379	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(15,353)	9,148	14,363	68	1,142	16,824	(239,750)	0	0	0	0	(213,558)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(250,892)	0	0	0	0	0	(10,103)	0	0	0	0	(260,995)	43
44	TOTAL Special Cost Centers	(250,892)	0	0	0	0	0	(10,103)	0	0	0	0	(260,995)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(310,406)	(6,815)	(16,907)	(41,953)	(50,609)	117,996	(206,269)	0	0	0	0	(514,963)	45

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
<u>Bravo Services, L.L.C.</u>	<u>100</u>	<u>See Page 6 - Supplemental</u>		<u>See Page 6 - Supplemental</u>		

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	<u>10 Nursing & Medical Records</u>	\$	<u>Bravo Nursing Home Services, Inc.</u>	<u>0.00%</u>	<u>\$ 43,713</u>	<u>\$ 43,713</u>	<u>1</u>
2	V	<u>15 Mgmt. Allocation of Benefits</u>		<u>Bravo Nursing Home Services, Inc.</u>	<u>0.00%</u>	<u>3,559</u>	<u>3,559</u>	<u>2</u>
3	V	<u>17 Mgmt Fee/Administrative</u>	<u>138,000</u>	<u>Bravo Nursing Home Services, Inc.</u>	<u>0.00%</u>	<u>14,794</u>	<u>(123,206)</u>	<u>3</u>
4	V	<u>19 Professional Services</u>		<u>Bravo Nursing Home Services, Inc.</u>	<u>0.00%</u>	<u>111</u>	<u>111</u>	<u>4</u>
5	V	<u>20 Dues, Fees, Subs & Promotions</u>		<u>Bravo Nursing Home Services, Inc.</u>	<u>0.00%</u>	<u>11</u>	<u>11</u>	<u>5</u>
6	V	<u>21 Clerical and General Office</u>		<u>Bravo Nursing Home Services, Inc.</u>	<u>0.00%</u>	<u>49,924</u>	<u>49,924</u>	<u>6</u>
7	V	<u>24 Travel and Seminar</u>		<u>Bravo Nursing Home Services, Inc.</u>	<u>0.00%</u>	<u>1,766</u>	<u>1,766</u>	<u>7</u>
8	V	<u>25 Other Admin. Staff Transport.</u>		<u>Bravo Nursing Home Services, Inc.</u>	<u>0.00%</u>	<u>2,670</u>	<u>2,670</u>	<u>8</u>
9	V	<u>26 Insurance-Prop./Liab./Malprac.</u>		<u>Bravo Nursing Home Services, Inc.</u>	<u>0.00%</u>	<u>304</u>	<u>304</u>	<u>9</u>
10	V	<u>27 Mgmt. Allocation of Benefits</u>		<u>Bravo Nursing Home Services, Inc.</u>	<u>0.00%</u>	<u>5,185</u>	<u>5,185</u>	<u>10</u>
11	V	<u>35 Rent-Equipment & Vehicles</u>		<u>Bravo Nursing Home Services, Inc.</u>	<u>0.00%</u>	<u>9,148</u>	<u>9,148</u>	<u>11</u>
12	V							<u>12</u>
13	V							<u>13</u>
14	Total		\$ 138,000			\$ 131,185	\$ * (6,815)	14

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$	Midwest Administrative Services, Inc.	0.00%	\$ 1,740	\$ 1,740
16	V	2 Food		Midwest Administrative Services, Inc.	0.00%	30	30
17	V	5 Utilities		Midwest Administrative Services, Inc.	0.00%	204	204
18	V	6 Maintenance		Midwest Administrative Services, Inc.	0.00%	152	152
19	V	7 Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	197	197
20	V	10 Nursing and Medical Records		Midwest Administrative Services, Inc.	0.00%	4,431	4,431
21	V	15 Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	500	500
22	V	17 Mgmt Fee/Administrative	161,640	Midwest Administrative Services, Inc.	0.00%	2,145	(159,495)
23	V	19 Professional Services		Midwest Administrative Services, Inc.	0.00%	8,491	8,491
24	V	20 Dues, Fees, Subs & Promotions		Midwest Administrative Services, Inc.	0.00%	1,499	1,499
25	V	21 Clerical and General Office		Midwest Administrative Services, Inc.	0.00%	96,150	96,150
26	V	24 Travel and Seminar		Midwest Administrative Services, Inc.	0.00%	2,901	2,901
27	V	25 Other Admin. Staff Transport.		Midwest Administrative Services, Inc.	0.00%	1,253	1,253
28	V	26 Insurance-Prop./Liab./Malprac.		Midwest Administrative Services, Inc.	0.00%	1,991	1,991
29	V	27 Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	8,686	8,686
30	V	30 Depreciation		Midwest Administrative Services, Inc.	0.00%	6,662	6,662
31	V	32 Interest		Midwest Administrative Services, Inc.	0.00%	479	479
32	V	34 Rent-Facility and Grounds		Midwest Administrative Services, Inc.	0.00%	5,991	5,991
33	V	35 Rent-Equipment & Vehicles		Midwest Administrative Services, Inc.	0.00%	1,231	1,231
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 161,640			\$ 144,733	\$ * (16,907)

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 Professional Services	\$ 57,849	Claims Administration Services, LLC	0.00%	\$ 640	\$ (57,209)
16	V	20 Dues, Fees, Subs & Promotions		Claims Administration Services, LLC	0.00%	271	271
17	V	21 Clerical and General Office		Claims Administration Services, LLC	0.00%	13,152	13,152
18	V	24 Travel and Seminar		Claims Administration Services, LLC	0.00%	108	108
19	V	25 Other Admin. Staff Transport.		Claims Administration Services, LLC	0.00%	264	264
20	V	26 Insurance-Prop./Liab./Malprac.		Claims Administration Services, LLC	0.00%	138	138
21	V	27 Mgmt. Allocation of Benefits		Claims Administration Services, LLC	0.00%	1,255	1,255
22	V	32 Interest		Claims Administration Services, LLC	0.00%	68	68
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 57,849			\$ 15,896	\$ * (41,953)

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 Utilities	\$	Senior Living Services, Inc.	0.00%	\$ 23	\$	23	15
16	V	6 Maintenance	137,103	Senior Living Services, Inc.	0.00%	73,750		(63,353)	16
17	V	7 Mgmt. Allocation of Benefits		Senior Living Services, Inc.	0.00%	4,455		4,455	17
18	V	20 Dues, Fees, Subs & Promotions		Senior Living Services, Inc.	0.00%	9		9	18
19	V	21 Clerical and General Office		Senior Living Services, Inc.	0.00%	684		684	19
20	V	24 Travel and Seminar		Senior Living Services, Inc.	0.00%	1,691		1,691	20
21	V	25 Other Admin. Staff Transport.		Senior Living Services, Inc.	0.00%	3,680		3,680	21
22	V	26 Insurance-Prop./Liab./Malprac.		Senior Living Services, Inc.	0.00%	1,060		1,060	22
23	V	30 Depreciation		Senior Living Services, Inc.	0.00%	1,142		1,142	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		\$ 137,103			\$ 86,494	\$ *	(50,609)	39

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	19 Professional Services	\$	Bravo Holding Company	0.00%	\$ 100,165	\$	100,165	15
16	V	21 Clerical and General Office		Bravo Holding Company	0.00%	453		453	16
17	V	24 Travel and Seminar		Bravo Holding Company	0.00%	65		65	17
18	V	26 Insurance-Prop./Liab./Malprac.		Bravo Holding Company	0.00%	489		489	18
19	V	32 Interest		Bravo Holding Company	0.00%	16,824		16,824	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		\$			\$ 117,996	\$ *	117,996	39

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 Administrative	\$	Joliet Real Estate Holding Company	0.00%	\$ 3,600	\$ 3,600
16	V	19 Professional Services		Joliet Real Estate Holding Company	0.00%	2,248	2,248
17	V	21 Clerical and General Office		Joliet Real Estate Holding Company	0.00%	1,499	1,499
18	V	26 Insurance-Prop./Liab./Malprac.		Joliet Real Estate Holding Company	0.00%	36,237	36,237
19	V	30 Depreciation		Joliet Real Estate Holding Company	0.00%	84,757	84,757
20	V	32 Interest		Joliet Real Estate Holding Company	0.00%	285,538	285,538
21	V	33 Real Estate Taxes		Joliet Real Estate Holding Company	0.00%	65,328	65,328
22	V	34 Rent-Facility and Grounds	675,373	Joliet Real Estate Holding Company	0.00%		(675,373)
23	V	43 Non-Allowable Expenses		Joliet Real Estate Holding Company	0.00%	(10,103)	(10,103)
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 675,373			\$ 469,104	\$ * (206,269)

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

Facility Name & ID Number

Rosewood Care Ctr of Joliet

0049130

Report Period Beginning:

07/01/2013

Ending:

06/30/2014

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			Bravo Care of East Alton, Inc.	Alton, IL	Bravo Care of Wood		Supportive Living	2
3			Bravo Care of East Peoria, Inc.	East Peoria, IL	River, Inc.	Wood River, IL	Facility	3
4			Bravo Care of Edwardsville, Inc.	Edwardsville, IL	Bravo Nursing Home			4
5			Bravo Care of Elgin, Inc.	Elgin, IL	Services, Inc.	St. Louis, MO	Management Co.	5
6			Bravo Care of Galeburg, Inc.	Galesburg, IL	Bravo Holding			6
7			Bravo Care of Inverness, Inc.	Inverness, IL	Company, Inc.	St. Louis, MO	Holding Co.	7
8			Bravo Care of Moline, Inc.	Moline, IL	Senior Living		Building Services	8
9			Bravo Care of Northbrook, Inc.	Northbrook, IL	Services, Inc.	St. Louis, MO	Company	9
10			Bravo Care of Peoria, Inc.	Peoria, IL	Bravo Team		Human Resources	10
11			Bravo Care of Rockford, Inc.	Rockford, IL	Health, Inc.	St. Louis, MO	Company	11
12			Bravo Care of St. Charles, Inc.	St. Charles, IL	Claims Administration		Legal Services	12
13			Bravo Care of St. Louis, Inc.	St. Louis, MO	Services, LLC	St. Louis, MO		13
14					Joliet Real Estate			14
15					Holding Company	Joliet, IL	Lessor	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 Ctr of Joliet # 0049130 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Michael Brady	President (Note 1)	Administrative	0.00	96,046	3.58	7.16	Salary	\$ 7,397	L17, C7	1
2	Mark Yampol	CEO (Note 2)	Administrative	0.00	27,857	3.58	7.16	Salary	2,145	L17, C7	2
3											3
4											4
5											5
6											6
7											7
8											8
9	Note 1: Michael Brady was the President of Bravo Nursing Home Services, Inc. from 7/1/13 to 12/30/13. When the stock of the companies were sold, Mr. Brady became										9
10	Director of Administrative Services and was no longer President. The wages above reflect only the period of time from when he was President.										10
11	Note 2: Mark Yampol is the CEO of Midwest Administrative Services, Inc. beginning 12/31/13, when the stock of the companies were purchased.										11
12	The wages above reflect only the period of time from 12/31/13 thru 6/30/14.										12
13								TOTAL	\$ 9,542		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 Ctr of Joliet

0049130 Report Period Beginning: 07/01/2013

Ending: 6/30/2014

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

Name of Related Organization Bravo Nursing Home Service
 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

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

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	Nursing & Medical Records	WeightedCensus	497,328	15	611,304	611,304	35,563	\$ 43,713	1
2	15	Mgmt. Allocation of Benefits	WeightedCensus	497,328	15	49,766		35,563	3,559	2
3	17	Administrative	WeightedCensus	497,328	15	206,886	206,886	35,563	14,794	3
4	19	Professional Services	WeightedCensus	497,328	15	1,560		35,563	111	4
5	20	Dues, Fees, Subs & Promotions	WeightedCensus	497,328	15	155		35,563	11	5
6	21	Clerical and General Office	WeightedCensus	497,328	15	698,165	683,784	35,563	49,924	6
7	24	Travel and Seminar	WeightedCensus	497,328	15	24,702		35,563	1,766	7
8	25	Other Admin. Staff Transport.	WeightedCensus	497,328	15	37,333		35,563	2,670	8
9	26	Insurance-Prop./Liab./Malprac.	WeightedCensus	497,328	15	4,250		35,563	304	9
10	27	Mgmt. Allocation of Benefits	WeightedCensus	497,328	15	72,507		35,563	5,185	10
11	35	Rent-Equipment & Vehicles	WeightedCensus	497,328	15	127,935		35,563	9,148	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21		** - Please note that the 15 subunits that are being allocated among include a facility in Swansea, IL. This facility was managed from								21
22		7/1/13 thru 3/31/14. The facility units used for the Swansea facility was based on the census through 3/31/14. The Swansea facility								22
23		is not a related party.								23
24										24
25	TOTALS					\$ 1,834,563	\$ 1,501,974		\$ 131,185	25

Facility Name & ID Number Rosewood Care Ctr of Joliet

0049130 Report Period Beginning: 07/01/2013

Ending: 6/30/2014

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

Name of Related Organization Midwest Administrative 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

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

1	2	3	4	5**	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	497,328	15	24,339	24,339	35,563	\$ 1,740	1	
2	2	Food	497,328	15	417		35,563	30	2	
3	5	Utilities	497,328	15	2,858		35,563	204	3	
4	6	Maintenance	497,328	15	2,125		35,563	152	4	
5	7	Mgmt. Allocation of Benefits	497,328	15	2,750		35,563	197	5	
6	10	Nursing and Medical Records	497,328	15	61,958	61,958	35,563	4,431	6	
7	15	Mgmt. Allocation of Benefits	497,328	15	6,997		35,563	500	7	
8	17	Administrative	497,328	15	30,003	30,003	35,563	2,145	8	
9	19	Professional Services	497,328	15	118,742		35,563	8,491	9	
10	20	Dues, Fees, Subs & Promotions	497,328	15	20,968		35,563	1,499	10	
11	21	Clerical and General Office	497,328	15	1,344,593	1,045,674	35,563	96,150	11	
12	24	Travel and Seminar	497,328	15	40,571		35,563	2,901	12	
13	25	Other Admin. Staff Transport.	497,328	15	17,516		35,563	1,253	13	
14	26	Insurance-Prop./Liab./Malprac.	497,328	15	27,838		35,563	1,991	14	
15	27	Mgmt. Allocation of Benefits	497,328	15	121,473		35,563	8,686	15	
16	30	Depreciation	497,328	15	93,160		35,563	6,662	16	
17	32	Interest	497,328	15	6,702		35,563	479	17	
18	34	Rent-Facility and Grounds	497,328	15	83,780		35,563	5,991	18	
19	35	Rent-Equipment & Vehicles	497,328	15	17,213		35,563	1,231	19	
20									20	
21		** - Please note that the 15 subunits that are being allocated among include a facility in Swansea, IL. This facility was managed from 7/1/13 thru 3/31/14. The facility units used for the Swansea facility was based on the census through 3/31/14. The Swansea facility is not a related party.								21
22										22
23										23
24										24
25	TOTALS				\$ 2,024,003	\$ 1,161,974		\$ 144,733	25	

Facility Name & ID Number Rosewood Care Ctr of Joliet

0049130 Report Period Beginning: 07/01/2013

Ending: 6/30/2014

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

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

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

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 Services	Weighted Census/Direct Exp 497,328	15	\$ 38,020	\$	35,563	\$ 640	1	
2	20	Dues, Fees, Subs & Promotions	Weighted Census 497,328	15	3,789		35,563	271	2	
3	21	Clerical and General Office	Weighted Census 497,328	15	183,917	183,869	35,563	13,152	3	
4	24	Travel and Seminar	Weighted Census 497,328	15	1,515		35,563	108	4	
5	25	Other Admin. Staff Transport.	Weighted Census 497,328	15	3,685		35,563	264	5	
6	26	Insurance-Prop./Liab./Malprac.	Weighted Census 497,328	15	1,930		35,563	138	6	
7	27	Mgmt. Allocation of Benefits	Weighted Census 497,328	15	17,550		35,563	1,255	7	
8	32	Interest	Weighted Census 497,328	15	957		35,563	68	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		** - Please note that the 15 subunits that are being allocated among include a facility in Swansea, IL. This facility was managed from 7/1/13 thru 3/31/14. The facility units used for the Swansea facility was based on the census through 3/31/14. The Swansea facility is not a related party.								21
22										22
23										23
24										24
25	TOTALS					\$ 251,363	\$ 183,869		\$ 15,896	25

Facility Name & ID Number Rosewood Care Ctr of Joliet

0049130 Report Period Beginning: 07/01/2013

Ending: 6/30/2014

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

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

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

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	Weighted Census	497,328	15	\$ 320	\$ 35,563	\$ 23	1	
2	6	Maintenance	Weighted Census/Direct Exp	497,328	15	998,295	573,323	35,563	73,750	2
3	7	Mgmt. Allocation of Benefits	Weighted Census	497,328	15	62,296	35,563	4,455	3	
4	20	Dues, Fees, Subs & Promotions	Weighted Census	497,328	15	120	35,563	9	4	
5	21	Clerical and General Office	Weighted Census	497,328	15	9,566	35,563	684	5	
6	24	Travel and Seminar	Weighted Census	497,328	15	23,651	35,563	1,691	6	
7	25	Other Admin. Staff Transport.	Weighted Census	497,328	15	51,467	35,563	3,680	7	
8	26	Insurance-Prop./Liab./Malprac.	Weighted Census	497,328	15	14,825	35,563	1,060	8	
9	30	Depreciation	Weighted Census	497,328	15	15,975	35,563	1,142	9	
10									10	
11									11	
12									12	
13									13	
14									14	
15									15	
16									16	
17									17	
18									18	
19									19	
20									20	
21	** - Please note that the 15 subunits that are being allocated among include a facility in Swansea, IL. This facility was managed from									
22	7/1/13 thru 3/31/14. The facility units used for the Swansea facility was based on the census through 3/31/14. The Swansea facility									
23	is not a related party.									
24									24	
25	TOTALS				\$ 1,176,515	\$ 573,323		\$ 86,494	25	

Facility Name & ID Number Rosewood Care Ctr of Joliet

0049130 Report Period Beginning: 07/01/2013

Ending: 6/30/2014

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

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

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

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 Services	Weighted Census	497,328	15	\$ 1,400,742	\$ 35,563	\$ 100,165	1
2	21	Clerical and General Office	Weighted Census	497,328	15	6,337	35,563	453	2
3	24	Travel and Seminar	Weighted Census	497,328	15	913	35,563	65	3
4	26	Insurance-Prop./Liab./Malprac.	Weighted Census	497,328	15	6,835	35,563	489	4
5	32	Interest	Weighted Census	497,328	15	235,278	35,563	16,824	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	** - Please note that the 15 subunits that are being allocated among include a facility in Swansea, IL. This facility was managed from								
22	7/1/13 thru 3/31/14. The facility units used for the Swansea facility was based on the census through 3/31/14. The Swansea facility								
23	is not a related party.								
24									24
25	TOTALS					\$ 1,650,105	\$	\$ 117,996	25

Facility Name & ID Number

Rosewood Care Ctr of Joliet

0049130

Report Period Beginning:

07/01/2013

Ending:

06/30/2014

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	A. Directly Facility Related																	
	Long-Term																	
1	Berkadia		X	Mortgage	\$91,297.26	4/1/04	\$ 14,104,500	\$ 12,508,374	5/1/39	0.0450	\$ 282,707	1						
2												2						
3												3						
4												4						
5												5						
	Working Capital																	
6	MidCap (Thru Allocation of		X	Revolving Line of Credit		8/1/09			12/31/14	0.0500	16,824	6						
7	Bravo Holding Co.)											7						
8												8						
9	TOTAL Facility Related				\$91,297.26		\$ 14,104,500	\$ 12,508,374			\$ 299,531	9						
	B. Non-Facility Related*																	
10											(15,376)	10						
11											2,854	11						
12											547	12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			(11,975)	14						
15	TOTALS (line 9+line14)						\$ 14,104,500	\$ 12,508,374			\$ 287,556	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 31,634 Line # 26

* 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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.					
1. Real Estate Tax accrual used on 2013 report.				\$	111,011	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.)	See Below			\$	113,324	2	
3. Under or (over) accrual (line 2 minus line 1).				\$	2,313	3	
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	119,070	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.				\$	121,383	7	
Real Estate Tax History:							
Real Estate Tax Bill for Calendar Year:	2009	87,304	8	FOR BHF USE ONLY			
Taxes Paid-2012	2010	92,609	9				
Taxes Paid-2013	2011	99,667	10				
Total Taxes Paid	2012	109,912	11				
	2013	116,736	12				
<u>Accrual based on prior year tax bill.</u>				13	FROM R. E. TAX STATEMENT FOR 2013	\$	13
<u>Note: The real estate entity was purchased on 12/31/13, therefore the beginning accrual used above reflects the accrued real estate tax balance as of 6/30/13 in order for the worksheet to compute properly.</u>				14	PLUS APPEAL COST FROM LINE 5	\$	14
<u>See explanation on Att Sch I</u>				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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rosewood Care Ctr of Joliet COUNTY Will
 FACILITY IDPH LICENSE NUMBER 0049130
 CONTACT PERSON REGARDING THIS REPORT Mary Offner
 TELEPHONE (314) 994-9070 FAX #: (314) 994-9912

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2013 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 2013.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>06-03-26-203-123-0000</u>	<u>Nursing Home</u>	\$ <u>116,735.66</u>	\$ <u>116,735.66</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>116,735.66</u></u>	\$ <u><u>116,735.66</u></u>

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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 Ctr of Joliet

0049130 Report Period Beginning:

07/01/2013 Ending:

06/30/2014

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 (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? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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

1. Total Amount Incurred: 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	<u>Nursing Home</u>	<u>203,860</u>	<u>1990</u>	<u>\$ 213,780</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	203,860		\$ 213,780	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	120	1990	1990	\$ 3,637,017	\$	40	\$ 45,463	\$ 45,463	\$ 2,136,748	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Building Improvements - Real Estate Entity									9
10										10
11	General Requirements		1991	25,516		25	511	511	23,985	11
12	Developer Fee		1991	41,501		25	830	830	39,011	12
13	Construction Period Interest		1991	20,364		25	408	408	19,142	13
14	Arch and Eng Fees		1991	4,459		25	89	89	4,191	14
15	Storm Sewer		1991	32,675		25	654	654	30,715	15
16	Lawn Sprinkler		1991	13,190		25	264	264	12,399	16
17	Landscaping		1991	60,077		25	1,202	1,202	56,472	17
18	Mass Grading		1991	54,747		25	1,095	1,095	51,462	18
19	Asphalt Paving		1991	48,390		25	968	968	45,487	19
20	Sanitary Sewer		1991	8,069		25	162	162	7,585	20
21	Water Line		1991	15,500		25	310	310	14,570	21
22	Driveway and Sidewalks		1991	55,932		25	1,119	1,119	52,576	22
23	Walk-in Cooler Refrigerator		1991	6,888		10			6,888	23
24	Sink		1991	2,049		10			2,049	24
25	Exhaust and Air Hood		1991	4,670		10			4,670	25
26	Fire Exting. System		1991	1,647		10			1,647	26
27	Combo Range/Hood		1991	3,925		10			3,925	27
28	Building Signage		1991	7,300		10			7,300	28
29	Generator Accessories		1991	15,764		10			15,764	29
30	Cubicle Curtain Track		1991	6,176		10			6,176	30
31	6 Stainless Doors		1991	2,685		10			2,685	31
32	Monument Sign		1991	3,193		10			3,193	32
33	Wallcovering		1991	19,849		10			19,849	33
34	Carpeting		1991	9,585		10			9,585	34
35	Nurse Call Station		1991	28,217		10			28,217	35
36	Fire Alarm System		1991	15,724		10			15,724	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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Building Improvements - Real Estate Entity, continued		\$	\$		\$	\$	\$	37
38									38
39	Door Bell	1991	1,026		10			1,026	39
40	Door Alarm	1991	5,773		10			5,773	40
41	Public Address	1991	5,022		10			5,022	41
42	Cable	1991	15,712		10			15,712	42
43	Hot Water Boiler	1991	6,792		10			6,792	43
44	Hot Water Heater	1991	7,841		10			7,841	44
45	Load Bank Generator	1997	3,945		10			3,945	45
46	Seal and Stripe New Parking Spaces	2003	11,439		25	229	229	4,919	46
47	Roof Replacement	2005	6,944		40	87	87	1,577	47
48	Water Softener	2005	5,116		10	256	256	4,519	48
49	Backflow Device	2005	8,892		10	445	445	7,706	49
50	Backflow Device for Water Heater	2005	1,984		10	99	99	1,719	50
51	Door Closers	2005	5,496		10	275	275	4,763	51
52	Patient Rooms Sinks	2006	23,683		10	1,184	1,184	19,736	52
53	Satellite System	2006	9,002		10	450	450	6,901	53
54	Seal and Patch Parking Lot	2006	5,055		25	101	101	1,550	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									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,268,831	\$		\$ 56,201	\$ 56,201	\$ 2,721,516	70

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

Facility Name & ID Number Rosewood Care Ctr of Joliet

0049130

Report Period Beginning:

07/01/2013

Ending:

06/30/2014

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,268,831	\$		\$ 56,201	\$ 56,201	\$ 2,721,516	1
2	Building Improvements - Real Estate Entity, continued								2
3									3
4	Heat Pumps	2007	3,004		10	150	150	2,027	4
5	Nurse Call System	2008	71,367		10	3,569	3,569	45,610	5
6	Fire Alarm System	2008	54,919		10	2,746	2,746	35,405	6
7	Carpet	2008	4,579		10	229	229	2,786	7
8	Fire Alarm System	2008	6,381		10	319	319	3,829	8
9	Nurse Call System	2008	14,550		10	728	728	8,609	9
10	Telephone System	2008	22,919		10	1,146	1,146	14,325	10
11	Concrete Pad for Dumpster	2009	4,350		10	218	218	2,211	11
12	Grease Trap	2009	6,115		10	306	306	3,261	12
13	Sprinkler System Pipe	2009	3,715		10	186	186	1,827	13
14	Parking Lot Seal and Stripe	2009	11,518		25	231	231	2,278	14
15	Cooling Tower	2010	88,905		10	4,446	4,446	37,785	15
16	Sprinkler Pipe	2010	11,181		10	559	559	4,752	16
17	Cooling Tower Addition	2010	1,350		10	68	68	540	17
18	Sprinkler	2010	3,884		10	194	194	1,424	18
19	Water Heater	2011	6,494		10	325	325	1,840	19
20	Paving/Concrete	2012	52,000		25	1,040	1,040	3,761	20
21	Cooling Tower Starter	2012	3,178		10	159	159	583	21
22	HVAC	2012	3,359		40	42	42	168	22
23	Exit Doors 1, 8 and 10, and beverage room door	2013	8,675		40	109	109	289	23
24	Sprinkler Repairs	2013	10,441		40	131	131	326	24
25	Architectural Fee	2013	8,273		40	86	86	172	25
26	Engineering & Surveying	2013	7,600		40	124	124	248	26
27	Doors	2014	9,061		40	54	54	107	27
28	HVAC Improvements	2014	45,798		10	1,145	1,145	2,290	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,732,447	\$		\$ 74,511	\$ 74,511	\$ 2,897,969	34

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

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		\$ 4,732,447	\$		\$ 74,511	\$ 74,511	\$ 2,897,969	1
2	Leasehold Improvements - Operating Entity								2
3									3
4	Painting	2007	11,934	1,705	7	1,705		11,224	4
5	Painting	2008	25,126	3,589	7	3,589		22,973	5
6	Wallpaper in assisted dining room	2013	5,785	826	7	826		895	6
7	Wallpaper-600 Hall, Crossover Hall, 100 Hall, Lobby, And short hall by Laundry Room	2014	10,570	311	7	311		311	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)		\$ 4,785,862	\$ 6,431		\$ 80,942	\$ 74,511	\$ 2,933,372	34

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

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	\$ 49,246	\$ 9,963	\$ 9,963	\$	5	\$ 16,260	71
72	Current Year Purchases	5,603	980	980		5	980	72
73	Fully Depreciated Assets							73
74		911,876		18,050	18,050		847,719	74
75	TOTALS	\$ 966,725	\$ 10,943	\$ 28,993	\$ 18,050		\$ 864,959	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 5,966,367	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 17,374	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 109,935	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 92,561	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,798,331	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	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 Ctr of Joliet

0049130

Report Period Beginning: 07/01/2013

Ending: 06/30/2014

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Joliet Real Estate Holding Company

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:	<u>1990</u>	<u>120</u>	<u>11/1/07</u>	\$ <u>830,728</u>	<u>5</u>	<u>Unlimited</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		<u>120</u>		\$ <u>830,728</u>			7

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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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 N/A.

N/A

9. Option to Buy: YES NO Terms: N/A *

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: \$ 32,614 Description: Medical Equipment \$19,175; Offsite Storage \$3,060, Home Office Allocation - \$10,379

(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	<u>N/A</u>		\$ _____	\$ _____	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 Ctr of Joliet # 0049130 Report Period Beginning: 07/01/2013 Ending: 06/30/2014
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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8		
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)			
			Units of Service			Units	Cost						
1	Licensed Occupational Therapist	10A(3)	hrs	\$	8,831	\$	461,394	\$	8,831	\$	461,394	1	
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,467		78,741		1,467		78,741	2	
3	Licensed Recreational Therapist		hrs									3	
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		9,313		529,133		9,313		532,323	4	
5	Physician Care		visits									5	
6	Dental Care		visits									6	
7	Work Related Program		hrs									7	
8	Habilitation		hrs									8	
9	Pharmacy	39(2)	# of prescrpts						498,337		498,337	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10	
11	Academic Education		hrs									11	
12	Other (specify):											12	
13	Other (specify):											13	
14	TOTAL			\$	19,611	\$	1,069,268	\$	501,527	19,611	\$	1,570,795	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.

Facility Name & ID Number Rosewood Care Ctr of Joliet

0049130

Report Period Beginning: 07/01/2013

Ending: 06/30/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2014 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 9,001	\$ 59,492	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>164,591</u>)	1,262,576	1,262,576	3
4	Supply Inventory (priced at <u>Cost</u>)	3,646	3,646	4
5	Short-Term Investments			5
6	Prepaid Insurance	38,054	40,957	6
7	Other Prepaid Expenses	3,434	3,434	7
8	Accounts Receivable (owners or related parties)	2,664,653	2,664,653	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,981,364	\$ 4,034,758	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		3,637,017	14
15	Leasehold Improvements, at Historical Cost	53,415	1,148,845	15
16	Equipment, at Historical Cost	54,849	966,725	16
17	Accumulated Depreciation (book methods)	(52,643)	(3,798,331)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		127,079	21
22	Other Long-Term Assets (spec <u>Loan Fees</u>)		255,719	22
23	Other(specify): <u>Deposits</u>	2,000	2,000	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 57,621	\$ 2,552,834	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,038,985	\$ 6,587,592	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 652,232	\$ 658,864	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	312,271	312,271	30
31	Accrued Taxes Payable (excluding real estate taxes)	31,128	31,128	31
32	Accrued Real Estate Taxes(Sch.IX-B)		119,070	32
33	Accrued Interest Payable		52,179	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	(159)	17,931	35
Other Current Liabilities(specify):				
36	<u>Accrued Expenses</u>	288,586	322,907	36
37	<u>Accrued Rent</u>	874,120		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,158,178	\$ 1,514,350	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		12,508,374	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)	\$	\$ 12,508,374	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,158,178	\$ 14,022,724	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,880,807	\$ (7,435,132)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,038,985	\$ 6,587,592	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,266,060	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,266,060	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	614,747	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)	\$ 614,747	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,880,807	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Rosewood Care Ctr of Joliet# 0049130Report Period Beginning: 07/01/2013Ending: 06/30/2014

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.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 13,011,749	1
2	Discounts and Allowances for all Levels	(3,348,263)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,663,486	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	211,028	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 211,028	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,400	13
14	Non-Patient Meals	3,628	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	53,123	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 59,151	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	94,076	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 94,076	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Attached Schedule</u>	6,150	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,150	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,033,891	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,200,770	31
32	Health Care	4,149,380	32
33	General Administration	1,448,449	33
B. Capital Expense			
34	Ownership	1,595,774	34
C. Ancillary Expense			
35	Special Cost Centers	807,795	35
36	Provider Participation Fee	216,976	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,419,144	40
41	Income before Income Taxes (line 30 minus line 40)**	614,747	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 614,747	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,362,716	44
45	Private Pay - Net Inpatient Revenue	2,751,806	45
46	Medicare - Net Inpatient Revenue	4,657,189	46
47	Other-(specify) <u>Insurance</u>	891,775	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,663,486	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.

Rosewood Care Ctr of Joliet

Period Beginning **07/01/2013**
Period End **06/30/2014**

Schedule 19A

Other Revenue:

Vending Income	1,160
Vendor Discount	1,662
Miscellaneous	3,328
	<hr/>
Total Other Revenue	<u>6,150</u>

Facility Name & ID Number Rosewood Care Ctr of Joliet

0049130

Report Period Beginning: 07/01/2013

Ending: 06/30/2014

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,080	2,360	\$ 84,202	\$ 35.68	1
2	Assistant Director of Nursing	1,160	1,281	32,295	25.21	2
3	Registered Nurses	23,564	25,304	767,858	30.35	3
4	Licensed Practical Nurses	19,149	20,767	481,819	23.20	4
5	CNAs & Orderlies	73,965	77,824	845,684	10.87	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,193	3,358	38,083	11.34	8
9	Activity Director	2,112	2,328	47,003	20.19	9
10	Activity Assistants	3,450	3,704	32,983	8.90	10
11	Social Service Workers	4,253	4,637	62,777	13.54	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,094	21,529	237,020	11.01	15
16	Dishwashers					16
17	Maintenance Workers	1,921	2,138	26,861	12.56	17
18	Housekeepers	15,595	16,594	149,870	9.03	18
19	Laundry	5,352	5,707	49,679	8.70	19
20	Administrator	2,104	2,288	98,322	42.97	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,597	10,250	106,366	10.38	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	4,752	5,161	56,582	10.96	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Sch 20A</u>	17,495	18,801	457,173	24.32	33
34	TOTAL (lines 1 - 33)	209,836	224,031	\$ 3,574,577 *	\$ 15.96	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 14,848	L1, C3	35
36	Medical Director	Monthly	18,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,369	L10, C3	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	799	L11, C3	44
45	Social Service Consultant	Monthly	2,400	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 41,416		49

C. CONTRACT NURSES

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

Rosewood Care Ctr of Joliet

Period Beginning 07/01/2013
Period End 06/30/2014

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Nurse	3,155	3,307	103,050	31.16
Case Manager	3,926	4,232	108,733	25.69
Rehabilitation Nurse	3,917	4,221	91,337	21.64
Ward Clerk	2,283	2,499	57,080	22.84
Marketing	4,214	4,542	96,973	21.35
TOTAL	<u>17,495</u>	<u>18,801</u>	<u>457,173</u>	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Bill Matjasich</u>	<u>Administrator</u>	<u>0</u>	<u>\$ 98,322</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 93,399</u>	<u>IDPH License Fee</u>	<u>\$ 1,990</u>	
				<u>Unemployment Compensation Insurance</u>	<u>67,054</u>	<u>Advertising: Employee Recruitment</u>	<u>3,514</u>	
				<u>FICA Taxes</u>	<u>268,323</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>34,469</u>	<u>(Indicate # of checks performed)</u>	<u>4,441</u>	
				<u>Employee Meals</u>		<u>Patient Background Checks</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Misc. Dues/Subscriptions/Fees</u>	<u>560</u>	
				<u>Employee Relations</u>	<u>1,857</u>	<u>Rosewood License Fee</u>	<u>1,500</u>	
				<u>Employee Uniforms</u>	<u>1,075</u>	<u>IHCA Dues</u>	<u>4,232</u>	
				<u>Employee Physicals</u>	<u>1,363</u>	<u>Misc. Licenses & Fees</u>	<u>1,370</u>	
				<u>Employee Drug Tests</u>	<u>252</u>	<u>Home Office Allocation</u>	<u>1,790</u>	
				<u>Tuition Reimbursement</u>	<u>497</u>	<u>Less: Public Relations Expense</u>	<u>()</u>	
						<u>Non-allowable advertising</u>	<u>()</u>	
						<u>Yellow page advertising</u>	<u>()</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 98,322	TOTAL (agree to Schedule V, line 22, col.8)	\$ 468,289	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 19,397	
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>Mgmt Fees-Bravo Nursing Home Svc-See Page 6, Elimon P 3, C 7</u>			<u>\$ 138,000</u>	<u>N/A</u>			<u>Out-of-State Travel</u>	<u>\$</u>
<u>Mgmt Fees-Midwest Admin Svc-See Page 6, Elimon P 3, C 7 from 1/1/14-6/30/14 (post-acquisition)</u>			<u>158,040</u>				<u>In-State Travel</u>	
							<u>Home Office Allocation</u>	<u>6,531</u>
							<u>Seminar Expense</u>	<u>271</u>
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 296,040	TOTAL		\$	<u>Entertainment Expense</u>	<u>()</u>
(Attach a copy of any management service agreement)							TOTAL (agree to Sch. V, line 24, col. 8)	\$ 6,802
C. Professional Services								
Vendor/Payee	Type		Amount					
<u>C.J. Schlosser & Company</u>	<u>Accountant/Consultant</u>		<u>\$ 100</u>					
<u>Hochschild, Bloom & Company</u>	<u>Accountant/Consultant</u>		<u>3,394</u>					
<u>Midwest Administrative Services</u>	<u>Administrative/Bookkeeping</u>		<u>168,815</u>					
<u>Claims Administration Services, Inc.</u>	<u>Related Party Legal Fees</u>		<u>57,849</u>					
<u>Amy Ostrolenk</u>	<u>Medical Record Review</u>		<u>1,050</u>					
<u>Chinnery Evans & Nail</u>	<u>Legal Fees</u>		<u>62</u>					
<u>Clerk of the Circuit Court</u>	<u>Court Costs</u>		<u>436</u>					
<u>County Court Reporters</u>	<u>Deposition Fee</u>		<u>287</u>					
<u>Daniel Maher</u>	<u>Legal Fees</u>		<u>29,264</u>					
<u>ElderCare Decisions</u>	<u>Medical Records Review</u>		<u>3,700</u>					
<u>Francine Buonavolanto</u>	<u>Deposition Fee</u>		<u>1,299</u>					
<u>See Attached Schedule</u>			<u>47,072</u>					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 313,328					
(For legal fee disclosure, see page 39 of instructions)								

* Attach copy of IMRF notifications

**See instructions.

Rosewood Care Ctr of Joliet

Period Beginning **07/01/2013**
Period End **06/30/2014**

Schedule 21A

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
George Rydman & Assoc	Deposition Fees	370
Healthcare Horizons	Healthcare Consulting	1,135
Jennifer Benco	Deposition Fee	176
Laner Muchin	Legal Fees	12,041
McCorkle Court Reporters	Transcript Fees	422
Mulherin, Rehfeldt & Varchetto	Legal Fees	21,216
Open Delta Consulting & Eldercare	Medical Record Review	1,841
Senior Care Capital	Closing Fees	7,500
Sullivan Reporting Company	Transcript Fee	320
Sun Times Media	Public Notice	57
US Legal Support, Inc.	Medical Records from Hospital	114
US Managed Care Services, LLC	Managed Care Network	200
Will County Circuit Court	Court Costs	1,680
	Total	<u>47,072</u>

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2	N/A											
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Rosewood Care Ctr of Joliet# 0049130Report Period Beginning: 07/01/2013Ending: 06/30/2014**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. 4,232 IHCA
- (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? 5 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 60,344 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. \$ 216,976
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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 4,788
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.