

Facility Name & ID Number Rosewood Care Ctr of Joliet

0049130 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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	9,965	15,020	8,996	33,981	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,965	15,020	8,996	33,981	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.58%

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

None (Do not include bed-hold days in Section B.)

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

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

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES

NO

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 6,472

Medicare Intermediary Novitas Solutions, Inc.

IV. ACCOUNTING BASIS

ACCRUAL

MODIFIED

CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

NO

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Rosewood Care Ctr of Joliet

0049130

Report Period Beginning:

07/01/2014

Ending:

06/30/2015

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	243,660	25,529	14,495	283,684		283,684	4,517	288,201		1
2	Food Purchase		230,299		230,299		230,299	(6,663)	223,636		2
3	Housekeeping	18,074	11,607	162,917	192,598		192,598		192,598		3
4	Laundry	7,088	17,862	108,611	133,561		133,561		133,561		4
5	Heat and Other Utilities			150,397	150,397		150,397	453	150,850		5
6	Maintenance	24,685	9,220	242,897	276,802		276,802	(62,030)	214,772		6
7	Other (specify):* <i>Allocated HO Benefits</i>							4,825	4,825		7
8	TOTAL General Services	293,507	294,517	679,317	1,267,341		1,267,341	(58,898)	1,208,443		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	2,645,261	223,914	6,452	2,875,627		2,875,627	50,785	2,926,412		10
10a	Therapy		2,478	942,743	945,221		945,221		945,221		10a
11	Activities	77,323	6,016	1,624	84,963		84,963		84,963		11
12	Social Services	62,817		2,400	65,217		65,217		65,217		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <i>Allocated HO Benefits</i>							5,388	5,388		15
16	TOTAL Health Care and Programs	2,785,401	232,408	971,219	3,989,028		3,989,028	56,173	4,045,201		16
	C. General Administration										
17	Administrative	102,601		413,896	516,497		516,497	(355,348)	161,149		17
18	Directors Fees										18
19	Professional Services			226,012	226,012		226,012	98,694	324,706		19
20	Dues, Fees, Subscriptions & Promotions			16,077	16,077		16,077	4,639	20,716		20
21	Clerical & General Office Expenses	100,100	21,481	151,570	273,151		273,151	182,283	455,434		21
22	Employee Benefits & Payroll Taxes			469,961	469,961		469,961		469,961		22
23	Inservice Training & Education										23
24	Travel and Seminar			197	197		197	10,206	10,403		24
25	Other Admin. Staff Transportation			8,680	8,680		8,680	1,812	10,492		25
26	Insurance-Prop.Liab.Malpractice			(132,752)	(132,752)		(132,752)	14,423	(118,329)		26
27	Other (specify):* <i>Allocated HO Benefits</i>							25,992	25,992		27
28	TOTAL General Administration	202,701	21,481	1,153,641	1,377,823		1,377,823	(17,299)	1,360,524		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,281,609	548,406	2,804,177	6,634,192		6,634,192	(20,024)	6,614,168		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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: 07/01/2014 Ending: 06/30/2015

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			16,168	16,168		16,168	187,152	203,320			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			33,429	33,429		33,429	129,516	162,945			32
33	Real Estate Taxes							119,070	119,070			33
34	Rent-Facility & Grounds			1,243,025	1,243,025		1,243,025	(1,230,801)	12,224			34
35	Rent-Equipment & Vehicles			34,087	34,087		34,087	2,168	36,255			35
36	Other (specify):* Mortgage Ins.							29,368	29,368			36
37	TOTAL Ownership			1,326,709	1,326,709		1,326,709	(763,527)	563,182			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		365,259		365,259		365,259		365,259			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			238,476	238,476		238,476		238,476			42
43	Other (specify):* See Att Sch 4A	98,639		86,526	185,165		185,165	(145,758)	39,407			43
44	TOTAL Special Cost Centers	98,639	365,259	325,002	788,900		788,900	(145,758)	643,142			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,380,248	913,665	4,455,888	8,749,801		8,749,801	(929,309)	7,820,492			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Care Ctr of Joliet

Period Beginning 07/01/2014

Period End 06/30/2015

Schedule 4A

V. Cost Center Expenses

		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
	Ancillary Expense										
	E. Special Cost Centers										
43	Other (specify):*				0		0		0		
	Laboratory/OP Expenses			18,021	18,021		18,021		18,021		
	Radiology Expenses			21,386	21,386		21,386		21,386		
	Non-Allowable Expenses	98,639		47,119	145,758		145,758	(145,758)	0		
					0		0		0		
					0		0		0		
	TOTAL Other Special Cost Centers	98,639	0	86,526	185,165	0	185,165	(145,758)	39,407		

Facility Name & ID Number Rosewood Care Ctr of Joliet

0049130

Report Period Beginning: 07/01/2014

Ending: 06/30/2015

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	(2,697)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,116)	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	(187,398)	32		10
11	Discounts, Allowances, Rebates & Refunds	(3,967)	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	(270)	20		17
18	Fines and Penalties	(421)	43		18
19	Entertainment	(54)	43		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,072)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(35,157)	43		24
25	Fund Raising, Advertising and Promotional	(3,869)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(502)	43		28
29	Other-Attach Schedule See Page 5A	(111,362)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (353,885)		\$	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)	(575,424)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (575,424)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (929,309)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Care Ctr of Joliet

ID# 0049130

Report Period Beginning: 07/01/2014

Ending: 06/30/2015

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Eliminate Marketing Salary	\$ (98,639)	43	1
2	Eliminate Lobbying & PAC Dues	(2,637)	20	2
3	Miscellaneous Income Offset	3,055	21	3
4	Management Fee-Real Estate Entity	(7,200)	17	4
5	Related Party Legal Fees- Real Estate Entity	(105)	19	5
6	Mileage Reimbursement Related to Marketing	(5,836)	25	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		(111,362)	49

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
Bravo Services, L.L.C.	100	See Page 6 - Supplemental		See Page 6 - Supplemental		

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

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

1	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	1 Dietary	\$	Bravo Nursing Home Services, Inc.	0.00%	\$ 812	\$ 812	1
2	V	6 Maintenance		Bravo Nursing Home Services, Inc.	0.00%	29	29	2
3	V	7 Mgmt. Allocation of Benefits		Bravo Nursing Home Services, Inc.	0.00%	86	86	3
4	V	10 Nursing & Medical Records		Bravo Nursing Home Services, Inc.	0.00%	40,609	40,609	4
5	V	15 Mgmt. Allocation of Benefits		Bravo Nursing Home Services, Inc.	0.00%	4,314	4,314	5
6	V	17 Administrative	138,000	Bravo Nursing Home Services, Inc.	0.00%	14,758	(123,242)	6
7	V	19 Professional Services		Bravo Nursing Home Services, Inc.	0.00%	114	114	7
8	V	20 Dues, Fees, Subs & Promotions		Bravo Nursing Home Services, Inc.	0.00%	57	57	8
9	V	21 Clerical and General Office		Bravo Nursing Home Services, Inc.	0.00%	49,065	49,065	9
10	V	24 Travel and Seminar		Bravo Nursing Home Services, Inc.	0.00%	2,199	2,199	10
11	V	25 Other Admin. Staff Transport.		Bravo Nursing Home Services, Inc.	0.00%	1,943	1,943	11
12	V	26 Insurance-Prop./Liab./Malprac.		Bravo Nursing Home Services, Inc.	0.00%	213	213	12
13	V	27 Mgmt. Allocation of Benefits		Bravo Nursing Home Services, Inc.	0.00%	6,649	6,649	13
14	Total		\$ 138,000			\$ 120,848	\$ * (17,152)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	<u>1</u> Dietary	\$	Midwest Administrative Services, Inc.	0.00%	\$ 3,705	\$ 3,705
16	V	<u>2</u> Food		Midwest Administrative Services, Inc.	0.00%	1	1
17	V	<u>5</u> Utilities		Midwest Administrative Services, Inc.	0.00%	147	147
18	V	<u>6</u> Maintenance		Midwest Administrative Services, Inc.	0.00%	1,124	1,124
19	V	<u>7</u> Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	391	391
20	V	<u>10</u> Nursing and Medical Records		Midwest Administrative Services, Inc.	0.00%	10,176	10,176
21	V	<u>15</u> Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	1,074	1,074
22	V	<u>17</u> Administrative	275,896	Midwest Administrative Services, Inc.	0.00%	43,790	(232,106)
23	V	<u>19</u> Professional Services		Midwest Administrative Services, Inc.	0.00%	7,790	7,790
24	V	<u>20</u> Dues, Fees, Subs & Promotions		Midwest Administrative Services, Inc.	0.00%	7,294	7,294
25	V	<u>21</u> Clerical and General Office	61,107	Midwest Administrative Services, Inc.	0.00%	161,365	100,258
26	V	<u>24</u> Travel and Seminar		Midwest Administrative Services, Inc.	0.00%	3,408	3,408
27	V	<u>25</u> Other Admin. Staff Transport.		Midwest Administrative Services, Inc.	0.00%	1,940	1,940
28	V	<u>26</u> Insurance-Prop./Liab./Malprac.		Midwest Administrative Services, Inc.	0.00%	3,922	3,922
29	V	<u>27</u> Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	17,559	17,559
30	V	<u>30</u> Depreciation		Midwest Administrative Services, Inc.	0.00%	16,456	16,456
31	V	<u>32</u> Interest		Midwest Administrative Services, Inc.	0.00%	13,116	13,116
32	V	<u>34</u> Rent-Facility and Grounds		Midwest Administrative Services, Inc.	0.00%	12,224	12,224
33	V	<u>35</u> Rent-Equipment & Vehicles		Midwest Administrative Services, Inc.	0.00%	2,168	2,168
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 337,003			\$ 307,650	\$ * (29,353)

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 86,526	Claims Administration Services, LLC	0.00%	\$ 288	\$ (86,238)
16	V	21 Clerical and General Office		Claims Administration Services, LLC	0.00%	16,596	16,596
17	V	24 Travel and Seminar		Claims Administration Services, LLC	0.00%	957	957
18	V	25 Other Admin. Staff Transport.		Claims Administration Services, LLC	0.00%	501	501
19	V	26 Insurance-Prop./Liab./Malprac.		Claims Administration Services, LLC	0.00%	213	213
20	V	27 Mgmt. Allocation of Benefits		Claims Administration Services, LLC	0.00%	1,784	1,784
21	V						
22	V						
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		\$ 86,526			\$ 20,339	\$ * (66,187)

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

SEE ACCOUNTANTS' COMPILATION REPORT

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%	\$ 306	\$	306	15
16	V	6 Maintenance	100,141	Senior Living Services, Inc.	0.00%	36,958		(63,183)	16
17	V	7 Mgmt. Allocation of Benefits		Senior Living Services, Inc.	0.00%	4,348		4,348	17
18	V	19 Professional Services		Senior Living Services, Inc.	0.00%	9		9	18
19	V	21 Clerical and General Office		Senior Living Services, Inc.	0.00%	748		748	19
20	V	24 Travel and Seminar		Senior Living Services, Inc.	0.00%	3,354		3,354	20
21	V	25 Other Admin. Staff Transport.		Senior Living Services, Inc.	0.00%	2,968		2,968	21
22	V	26 Insurance-Prop./Liab./Malprac.		Senior Living Services, Inc.	0.00%	875		875	22
23	V	30 Depreciation		Senior Living Services, Inc.	0.00%	1,204		1,204	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		\$ 100,141			\$ 50,770	\$ *	(49,371)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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%	\$ 172,001	\$	172,001	15
16	V	20 Fees & Subscriptions		Bravo Holding Company	0.00%	65		65	16
17	V	21 Clerical and General Office		Bravo Holding Company	0.00%	879		879	17
18	V	24 Travel and Seminar		Bravo Holding Company	0.00%	288		288	18
19	V	25 Other Admin. Staff Transport.		Bravo Holding Company	0.00%	296		296	19
20	V	26 Insurance-Prop./Liab./Malprac.		Bravo Holding Company	0.00%	703		703	20
21	V	32 Interest		Bravo Holding Company	0.00%	18,490		18,490	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		\$			\$ 192,722	\$ *	192,722	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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%	\$ 7,200	\$ 7,200
16	V	19 Professional Services		Joliet Real Estate Holding Company	0.00%	6,195	6,195
17	V	20 Dues & Subscriptions		Joliet Real Estate Holding Company	0.00%	130	130
18	V	21 Clerical and General Office		Joliet Real Estate Holding Company	0.00%	11,682	11,682
19	V	26 Insurance-Prop./Liab./Malprac.		Joliet Real Estate Holding Company	0.00%	8,497	8,497
20	V	30 Depreciation		Joliet Real Estate Holding Company	0.00%	169,492	169,492
21	V	32 Interest	36	Joliet Real Estate Holding Company	0.00%	285,344	285,308
22	V	33 Real Estate Taxes		Joliet Real Estate Holding Company	0.00%	119,070	119,070
23	V	34 Rent-Facility and Grounds	1,243,025	Joliet Real Estate Holding Company	0.00%		(1,243,025)
24	V	36 Mortgage Insurance		Joliet Real Estate Holding Company	0.00%	29,368	29,368
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		\$ 1,243,061			\$ 636,978	\$ * (606,083)

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Joliet # 0049130 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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	Mark Yampol	CEO	Administrative	0.00	56,583	4.97	9.94	Salary	4,407	L17, C7	1
2	Mark Yampol	CEO	Administrative	0.00	1,391,617	See Above	See Above	Consulting	108,383	L19, C7	2
3	Hillel Yampol	Owner	Administrative	0.00	44,660	4.97	9.94	Salary	3,478	L17, C7	3
4	Christene Rene Yampol	Owner	Administrative	0.00	66,807	4.97	9.94	Salary	5,203	L17, C7	4
5											5
6	See Attached Schedule 7A										6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 121,471		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Joliet

0049130 Report Period Beginning: 07/01/2014

Ending: 6/30/2015

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 Services
 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	470,290	14	11,239	11,239	33,981	\$ 812	1
2	6	Maintenance	470,290	14	397		33,981	29	2
3	7	Mgmt. Allocation of Benefits	470,290	14	1,193		33,981	86	3
4	10	Nursing & Medical Records	470,290	14	562,016	562,016	33,981	40,609	4
5	15	Mgmt. Allocation of Benefits	470,290	14	59,699		33,981	4,314	5
6	17	Administrative	470,290	14	204,253	204,253	33,981	14,758	6
7	19	Professional Services	470,290	14	1,579		33,981	114	7
8	20	Dues, Fees, Subs & Promotions	470,290	14	786		33,981	57	8
9	21	Clerical and General Office	470,290	14	679,056	662,076	33,981	49,065	9
10	24	Travel and Seminar	470,290	14	30,438		33,981	2,199	10
11	25	Other Admin. Staff Transport.	470,290	14	26,889		33,981	1,943	11
12	26	Insurance-Prop./Liab./Malprac.	470,290	14	2,943		33,981	213	12
13	27	Mgmt. Allocation of Benefits	470,290	14	92,023		33,981	6,649	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,672,511	\$ 1,439,584		\$ 120,848	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Joliet

0049130

Report Period Beginning:

07/01/2014

Ending: 6/30/2015

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	470,290	14	51,283	51,283	33,981	\$ 3,705	1
2	2	Food	470,290	14	13		33,981	1	2
3	5	Utilities	470,290	14	2,032		33,981	147	3
4	6	Maintenance	470,290	14	15,554		33,981	1,124	4
5	7	Mgmt. Allocation of Benefits	470,290	14	5,409		33,981	391	5
6	10	Nursing and Medical Records	470,290	14	140,839	140,839	33,981	10,176	6
7	15	Mgmt. Allocation of Benefits	470,290	14	14,860		33,981	1,074	7
8	17	Administrative	470,290	14	606,045	606,045	33,981	43,790	8
9	19	Professional Services	470,290	14	107,816		33,981	7,790	9
10	20	Dues, Fees, Subs & Promotions	470,290	14	100,942		33,981	7,294	10
11	21	Clerical and General Office	470,290	14	2,233,257	1,697,067	33,981	161,365	11
12	24	Travel and Seminar	470,290	14	47,164		33,981	3,408	12
13	25	Other Admin. Staff Transport.	470,290	14	26,845		33,981	1,940	13
14	26	Insurance-Prop./Liab./Malprac.	470,290	14	54,274		33,981	3,922	14
15	27	Mgmt. Allocation of Benefits	470,290	14	243,011		33,981	17,559	15
16	30	Depreciation	470,290	14	227,745		33,981	16,456	16
17	32	Interest	470,290	14	181,530		33,981	13,116	17
18	34	Rent-Facility and Grounds	470,290	14	169,173		33,981	12,224	18
19	35	Rent-Equipment & Vehicles	470,290	14	30,003		33,981	2,168	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 4,257,795	\$ 2,495,234		\$ 307,650	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Joliet

0049130

Report Period Beginning: 07/01/2014

Ending: 6/30/2015

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	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	19	Professional Services	Weighted Census	470,290	14	3,980	33,981	\$ 288	1
2	21	Clerical and General Office	Weighted Census	470,290	14	229,689	33,981	16,596	2
3	24	Travel and Seminar	Weighted Census	470,290	14	13,239	33,981	957	3
4	25	Other Admin. Staff Transport.	Weighted Census	470,290	14	6,938	33,981	501	4
5	26	Insurance-Prop./Liab./Malprac.	Weighted Census	470,290	14	2,943	33,981	213	5
6	27	Mgmt. Allocation of Benefits	Weighted Census	470,290	14	24,684	33,981	1,784	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					\$ 281,473	\$ 226,926	\$ 20,339	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Joliet

0049130 Report Period Beginning: 07/01/2014

Ending: 6/30/2015

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	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	5	Utilities	Weighted Census	470,290	14	4,237	33,981	\$ 306	1	
2	6	Maintenance	Weighted Census/Direct Exp	470,290	14	513,005	471,253	33,981	36,958	2
3	7	Mgmt. Allocation of Benefits	Weighted Census	470,290	14	60,169	33,981	33,981	4,348	3
4	19	Professional Services	Weighted Census	470,290	14	123	33,981	33,981	9	4
5	21	Clerical and General Office	Weighted Census	470,290	14	10,353	33,981	33,981	748	5
6	24	Travel and Seminar	Weighted Census	470,290	14	46,417	33,981	33,981	3,354	6
7	25	Other Admin. Staff Transport.	Weighted Census	470,290	14	41,082	33,981	33,981	2,968	7
8	26	Insurance-Prop./Liab./Malprac.	Weighted Census	470,290	14	12,112	33,981	33,981	875	8
9	30	Depreciation	Weighted Census	470,290	14	16,668	33,981	33,981	1,204	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					\$ 704,166	\$ 471,253	\$	50,770	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Joliet

0049130

Report Period Beginning:

07/01/2014

Ending: 6/30/2015

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	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	19	Professional Services	470,290	14	2,380,463		33,981	\$ 172,001	1
2	20	Fees & Subscriptions	470,290	14	901		33,981	65	2
3	21	Clerical and General Office	470,290	14	12,160		33,981	879	3
4	24	Travel and Seminar	470,290	14	3,989		33,981	288	4
5	25	Other Admin. Staff Transport.	470,290	14	4,094		33,981	296	5
6	26	Insurance-Prop./Liab./Malprac.	470,290	14	9,723		33,981	703	6
7	32	Interest	470,290	14	255,901		33,981	18,490	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				\$ 2,667,231	\$		\$ 192,722	25

SEE ACCOUNTANTS' COMPILATION REPORT

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		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	\$ 12,347,356	5/1/39	0.0450	\$ 279,636	1					
2												2					
3												3					
4												4					
5												5					
Working Capital																	
6	MidCap (Thru Allocation of		X	Revolving Line of Credit		8/1/09			12/31/15	5.0000	33,429	6					
7	Bravo Holding Co.)											7					
8												8					
9	TOTAL Facility Related				\$91,297.26		\$ 14,104,500	\$ 12,347,356			\$ 313,065	9					
B. Non-Facility Related*																	
10							Less: Interest Income Offset				(187,434)	10					
11							Amortization Expense				5,708	11					
12							Allocated from Mgmt Co's				31,606	12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			(150,120)	14					
15	TOTALS (line 9+line14)						\$ 14,104,500	\$ 12,347,356			\$ 162,945	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 29,368 Line # 36

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

2014 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 2014 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 2014.

(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>118,435.30</u>	\$ <u>118,435.30</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>118,435.30</u></u>	\$ <u><u>118,435.30</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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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.**

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>	1
2					2
3	TOTALS	203,860		\$ 213,780	3

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 90,925	\$ 90,925	\$ 2,227,673	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	1,021	1,021	25,006	11
12	Developer Fee		1991	41,501		25	1,660	1,660	40,671	12
13	Construction Period Interest		1991	20,364		25	815	815	19,957	13
14	Arch and Eng Fees		1991	4,459		25	178	178	4,369	14
15	Storm Sewer		1991	32,675		25	1,307	1,307	32,022	15
16	Lawn Sprinkler		1991	13,190		25	528	528	12,927	16
17	Landscaping		1991	60,077		25	2,403	2,403	58,875	17
18	Mass Grading		1991	54,747		25	2,190	2,190	53,652	18
19	Asphalt Paving		1991	48,390		25	1,936	1,936	47,423	19
20	Sanitary Sewer		1991	8,069		25	323	323	7,908	20
21	Water Line		1991	15,500		25	620	620	15,190	21
22	Driveway and Sidewalks		1991	55,932		25	2,237	2,237	54,813	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

SEE ACCOUNTANTS' COMPILATION REPORT

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	458	458	5,377	46
47	Roof Replacement	2005	6,944		40	174	174	1,751	47
48	Water Softener	2005	5,116		10	512	512	5,031	48
49	Backflow Device	2005	8,892		10	889	889	8,595	49
50	Backflow Device for Water Heater	2005	1,984		10	198	198	1,917	50
51	Door Closers	2005	5,496		10	550	550	5,313	51
52	Patient Rooms Sinks	2006	23,683		10	2,368	2,368	22,104	52
53	Satellite System	2006	9,002		10	900	900	7,801	53
54	Seal and Patch Parking Lot	2006	5,055		25	202	202	1,752	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	\$		\$ 112,394	\$ 112,394	\$ 2,833,910	70

SEE ACCOUNTANTS' COMPILATION REPORT

**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:

07/01/2014

Ending:

06/30/2015

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	\$		\$ 112,394	\$ 112,394	\$ 2,833,910	1
2	Building Improvements - Real Estate Entity, continued								2
3									3
4	Heat Pumps	2007	3,004		10	300	300	2,327	4
5	Nurse Call System	2008	71,367		10	7,137	7,137	52,747	5
6	Fire Alarm System	2008	54,919		10	5,492	5,492	40,897	6
7	Carpet	2008	4,579		10	458	458	3,244	7
8	Fire Alarm System	2008	6,381		10	638	638	4,467	8
9	Nurse Call System	2008	14,550		10	1,455	1,455	10,064	9
10	Telephone System	2008	22,919		10	2,292	2,292	16,617	10
11	Concrete Pad for Dumpster	2009	4,350		10	435	435	2,646	11
12	Grease Trap	2009	6,115		10	612	612	3,873	12
13	Sprinkler System Pipe	2009	3,715		10	372	372	2,199	13
14	Parking Lot Seal and Stripe	2009	11,518		25	461	461	2,739	14
15	Cooling Tower	2010	88,905		10	8,891	8,891	46,676	15
16	Sprinkler Pipe	2010	11,181		10	1,118	1,118	5,870	16
17	Cooling Tower Addition	2010	1,350		10	135	135	675	17
18	Sprinkler	2010	3,884		10	388	388	1,812	18
19	Water Heater	2011	6,494		10	649	649	2,489	19
20	Paving/Concrete	2012	52,000		25	2,080	2,080	5,841	20
21	Cooling Tower Starter	2012	3,178		10	318	318	901	21
22	HVAC	2012	3,359		40	84	84	252	22
23	Exit Doors 1, 8 and 10, and beverage room door	2013	8,675		40	217	217	506	23
24	Sprinkler Repairs	2013	10,441		40	261	261	587	24
25	Architectural Fee	2013	8,273		40	207	207	379	25
26	Engineering & Surveying	2013	7,600		40	304	304	552	26
27	Doors	2014	9,061		40	226	226	333	27
28	HVAC Improvements	2014	45,798		10	4,580	4,580	6,870	28
29	Seal Coating	2014	4,200		25	110	110	110	29
30	Asphalt Repair	2014	4,425		25	133	133	133	30
31	Parking Lot Light	2014	3,660		25	168	168	168	31
32	Electric Power Feeds-Baseboard Heaters in Dining Room	2014	3,485		10	232	232	232	32
33	Sewer Stoppage/Plumbing Repairs	2014	6,477		40	121	121	121	33
34	TOTAL (lines 1 thru 33)		\$ 4,754,694	\$		\$ 152,268	\$ 152,268	\$ 3,050,237	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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		\$ 4,754,694	\$		\$ 152,268	\$ 152,268	\$ 3,050,237	1
2	Leasehold Improvements - Operating Entity								2
3									3
4	Painting	2007	11,934	710	7	710		11,934	4
5	Painting	2008	25,126	2,153	7	2,153		25,126	5
6	Wallpaper in assisted dining room	2013	5,785	826	7	826		1,721	6
7	Wallpaper-600 Hall, Crossover Hall, 100 Hall, Lobby. And short hall by Laundry Room	2014	10,570	1,510	7	1,510		1,821	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)		\$ 4,808,109	\$ 5,199		\$ 157,467	\$ 152,268	\$ 3,090,839	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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	\$ 54,849	\$ 10,969	\$ 10,969	\$	5	\$ 28,209	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Allocated from Mgmt Co/Real Estate Entity	921,808		34,884	34,884		864,943	74
75	TOTALS	\$ 976,657	\$ 10,969	\$ 45,853	\$ 34,884		\$ 893,152	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	N/A									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)	\$ 5,998,546	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 16,168	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 203,320	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 187,152	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,983,991	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	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Joliet

0049130

Report Period Beginning: 07/01/2014

Ending: 06/30/2015

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								5
6	Allocated from Mgmt Co's				12,224			6
7	TOTAL				\$ 12,224			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.	<u>/2016</u>	\$ _____
-----	--------------	----------

13.	<u>/2017</u>	\$ _____
-----	--------------	----------

14.	<u>/2018</u>	\$ _____
-----	--------------	----------

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: \$ 36,255 Description: Offsite Storage - \$3,060, Medical Equipment - \$31,027, Home Office Allocation - \$2,168

(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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Joliet # 0049130 Report Period Beginning: 07/01/2014 Ending: 06/30/2015
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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			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	10A(3)	hrs	\$	7,150	\$	371,798	\$	7,150	\$	371,798					1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,487		80,298		1,487		80,298					2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		8,608		490,647		8,608		493,125					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								365,259				365,259	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			\$	17,245	\$	942,743	\$	17,245	\$	1,310,480					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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Joliet

0049130

Report Period Beginning: 07/01/2014

Ending: 06/30/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2015 (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	\$ (26,235)	\$ (22,809)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>194,000</u>)	1,336,336	1,336,336	3
4	Supply Inventory (priced at <u>Cost</u>)	4,392	4,392	4
5	Short-Term Investments			5
6	Prepaid Insurance	25,858	29,214	6
7	Other Prepaid Expenses	4,651	4,651	7
8	Accounts Receivable (owners or related parties)	4,227,472	4,237,472	8
9	Other(specify): <u>Insurance Deductible AR</u>	2,187	2,187	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,574,661	\$ 5,591,443	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		3,643,494	14
15	Leasehold Improvements, at Historical Cost	53,415	1,164,615	15
16	Equipment, at Historical Cost	54,849	976,657	16
17	Accumulated Depreciation (book methods)	(68,811)	(3,983,991)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		49,433	21
22	Other Long-Term Assets (spec <u>Loan Fees</u>)		250,011	22
23	Other(specify): <u>Deposits</u>	2,000	2,000	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 41,453	\$ 2,315,999	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,616,114	\$ 7,907,442	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,083,823	\$ 1,073,437	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	171,118	171,118	30
31	Accrued Taxes Payable (excluding real estate taxes)	46,673	46,673	31
32	Accrued Real Estate Taxes(Sch.IX-B)		120,555	32
33	Accrued Interest Payable		8,487	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	(159)	28,931	35
Other Current Liabilities(specify):				
36	<u>Accrued Expenses</u>	763,439	774,639	36
37	<u>Accrued Rent</u>	1,505,118		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,570,012	\$ 2,223,840	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		12,347,356	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)	\$	\$ 12,347,356	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,570,012	\$ 14,571,196	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,046,102	\$ (6,663,754)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,616,114	\$ 7,907,442	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,880,807	1
2	Restatements (describe):		2
3	Prior period post closing adjustments	(193,651)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,687,156	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	358,946	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)	\$ 358,946	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,046,102	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Joliet# 0049130Report Period Beginning: 07/01/2014Ending: 06/30/2015

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	\$ 11,280,354	1
2	Discounts and Allowances for all Levels	(2,690,530)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,589,824	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	255,881	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 255,881	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	1,600	13
14	Non-Patient Meals	2,400	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	75	20
21	Other Medical Services	70,360	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 74,435	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	187,398	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 187,398	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached Schedule 19A	1,209	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,209	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,108,747	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,267,341	31
32	Health Care	3,989,028	32
33	General Administration	1,377,823	33
B. Capital Expense			
34	Ownership	1,326,709	34
C. Ancillary Expense			
35	Special Cost Centers	550,424	35
36	Provider Participation Fee	238,476	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,749,801	40
41	Income before Income Taxes (line 30 minus line 40)**	358,946	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 358,946	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,482,078	44
45	Private Pay - Net Inpatient Revenue	3,061,988	45
46	Medicare - Net Inpatient Revenue	3,145,551	46
47	Other-(specify) <u>Insurance/Managed Care</u>	900,207	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,589,824	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Care Ctr of Joliet

Period Beginning 07/01/2014
Period End 06/30/2015

Schedule 19A

Other Revenue:

Vending Income	297
Vendor Discount	3,967
Miscellaneous	(3,055)

Total Other Revenue	<u>1,209</u>
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Facility Name & ID Number Rosewood Care Ctr of Joliet

0049130

Report Period Beginning: 07/01/2014

Ending: 06/30/2015

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	2,160	2,328	\$ 85,075	\$ 36.54	1
2	Assistant Director of Nursing	910	956	31,194	32.63	2
3	Registered Nurses	28,642	31,028	808,867	26.07	3
4	Licensed Practical Nurses	17,807	19,560	435,478	22.26	4
5	CNAs & Orderlies	74,026	78,825	828,795	10.51	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,670	3,240	37,611	11.61	8
9	Activity Director	2,635	2,967	46,566	15.69	9
10	Activity Assistants	3,153	3,436	30,757	8.95	10
11	Social Service Workers	4,624	5,048	62,817	12.44	11
12	Dietician					12
13	Food Service Supervisor	2,136	2,184	37,331	17.09	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,391	21,627	206,329	9.54	15
16	Dishwashers					16
17	Maintenance Workers	1,945	2,146	24,685	11.50	17
18	Housekeepers	1,110	1,765	18,074	10.24	18
19	Laundry	508	728	7,088	9.74	19
20	Administrator	2,329	2,698	102,601	38.03	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,084	9,900	100,100	10.11	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	4,974	5,450	56,056	10.29	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Sch 20A</u>	15,279	16,663	460,824	27.66	33
34	TOTAL (lines 1 - 33)	194,383	210,549	\$ 3,380,248 *	\$ 16.05	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	\$ 14,495	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	7,276	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	1,624	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)		\$ 43,795		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

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Care Ctr of Joliet

Period Beginning 07/01/2014
Period End 06/30/2015

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	2,777	2,881	93,962	32.61
Case Manager	2,952	3,475	113,672	32.71
Rehabilitation Nurse	3,108	3,336	100,109	30.01
Ward Clerk	2,164	2,476	54,442	21.99
Marketing	4,278	4,495	98,639	21.94
TOTAL	<u>15,279</u>	<u>16,663</u>	<u>460,824</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>\$ 102,601</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 94,780</u>	<u>IDPH License Fee</u>	<u>\$ 1,990</u>	
				<u>Unemployment Compensation Insurance</u>	<u>62,966</u>	<u>Advertising: Employee Recruitment</u>	<u>896</u>	
				<u>FICA Taxes</u>	<u>255,615</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>48,839</u>	<u>(Indicate # of checks performed <u>390</u>)</u>	<u>4,296</u>	
				<u>Employee Meals</u>		<u>Patient Background Checks</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>				
				<u>Employee Relations</u>	<u>2,286</u>	<u>Misc. Dues/Subscriptions/Fees</u>	<u>703</u>	
				<u>Employee Uniforms</u>	<u>1,002</u>	<u>IHCA Dues</u>	<u>4,232</u>	
				<u>Employee Physicals</u>	<u>741</u>	<u>Misc. Licenses</u>	<u>1,323</u>	
				<u>Employee Drug Tests</u>	<u>504</u>	<u>Home Office Allocation</u>	<u>7,546</u>	
				<u>Tuition Reimbursement</u>	<u>10</u>	<u>Less: Public Relations Expense</u>	<u>(270)</u>	
				<u>401K Expense</u>	<u>3,218</u>	<u>Non-allowable advertising</u>	<u>()</u>	
						<u>Yellow page advertising</u>	<u>()</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 102,601	TOTAL (agree to Schedule V, line 22, col.8)	\$ 469,961	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 20,716	
(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 Pg 6, Elim on 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 Pg 6, Elim on P 3, C 7</u>			<u>275,896</u>					
							<u>In-State Travel</u>	<u>127</u>
							<u>Home Office Allocation</u>	<u>10,206</u>
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 413,896				<u>Seminar Expense</u>	<u>70</u>
(Attach a copy of any management service agreement)								
C. Professional Services				TOTAL			Entertainment Expense	
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)	
<u>Hochschild, Bloom & Company</u>	<u>Accountant/Consultant</u>		<u>\$ 3,120</u>					
<u>WestLaw</u>	<u>Computer Consulting</u>		<u>14,898</u>					
<u>Odessa Healthcare</u>	<u>Consultant</u>		<u>75,303</u>					
<u>Claims Administration Services, Inc.</u>	<u>Related Party Legal Fees</u>		<u>86,526</u>					
<u>Myers Carden & Sax LLC</u>	<u>Legal Fees</u>		<u>12,148</u>					
<u>Mulherin, Rehfeldt & Varchetto, P.C</u>	<u>Legal Fees</u>		<u>17,779</u>					
<u>Laner Muchin</u>	<u>Legal Fees</u>		<u>2,623</u>					
<u>Daniel Maher</u>	<u>Legal Fees</u>		<u>4,352</u>					
<u>Hamlin & Burton Liability Manager</u>	<u>Insurance Consultant</u>		<u>(500)</u>					
<u>Various</u>	<u>Various below \$200</u>		<u>272</u>					
<u>Various</u>	<u>Deposition/Witness/Court Costs</u>		<u>9,491</u>					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 226,012					
(For legal fee disclosure, see page 39 of instructions)								

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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												
3	N/A											
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Joliet# 0049130Report Period Beginning: 07/01/2014Ending: 06/30/2015**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? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 55,746 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. \$ 238,476
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. \$ 2,697
- (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.

SEE ACCOUNTANTS' COMPILATION REPORT