

Facility Name & ID Number Rosewood Care Ctr of Rockfrd

0049270 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	14,836	9,330	5,396	29,562	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,836	9,330	5,396	29,562	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.49%

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 12/1/07

J. Was the facility purchased or leased after January 1, 1978? YES Date 12/1/07 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 4,132

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: 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 Rockfrd

0049270

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	241,501	14,971	16,385	272,857		272,857	3,930	276,787		1
2	Food Purchase		183,574		183,574		183,574	(6,522)	177,052		2
3	Housekeeping	18,114	8,886	157,892	184,892		184,892		184,892		3
4	Laundry	5,627	11,669	105,261	122,557		122,557		122,557		4
5	Heat and Other Utilities			115,463	115,463		115,463	394	115,857		5
6	Maintenance	36,361	7,361	153,374	197,096		197,096	(9,811)	187,285		6
7	Other (specify):* <i>Allocated HO Benefits</i>							4,197	4,197		7
8	TOTAL General Services	301,603	226,461	548,375	1,076,439		1,076,439	(7,812)	1,068,627		8
	B. Health Care and Programs										
9	Medical Director			9,900	9,900		9,900		9,900		9
10	Nursing and Medical Records	2,403,792	187,023	41,619	2,632,434		2,632,434	44,181	2,676,615		10
10a	Therapy		1,287	614,922	616,209		616,209		616,209		10a
11	Activities	56,909	4,240	2,600	63,749		63,749		63,749		11
12	Social Services	55,996		2,600	58,596		58,596		58,596		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <i>Allocated HO Benefits</i>							4,687	4,687		15
16	TOTAL Health Care and Programs	2,516,697	192,550	671,641	3,380,888		3,380,888	48,868	3,429,756		16
	C. General Administration										
17	Administrative	100,510		327,355	427,865		427,865	(276,421)	151,444		17
18	Directors Fees										18
19	Professional Services			137,028	137,028		137,028	150,071	287,099		19
20	Dues, Fees, Subscriptions & Promotions			10,798	10,798		10,798	5,434	16,232		20
21	Clerical & General Office Expenses	102,523	19,534	141,840	263,897		263,897	144,596	408,493		21
22	Employee Benefits & Payroll Taxes			411,764	411,764		411,764		411,764		22
23	Inservice Training & Education			140	140		140		140		23
24	Travel and Seminar			152	152		152	8,879	9,031		24
25	Other Admin. Staff Transportation			4,839	4,839		4,839	4,809	9,648		25
26	Insurance-Prop.Liab.Malpractice			18,986	18,986		18,986	13,423	32,409		26
27	Other (specify):* <i>Allocated HO Benefits</i>							22,611	22,611		27
28	TOTAL General Administration	203,033	19,534	1,052,902	1,275,469		1,275,469	73,402	1,348,871		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,021,333	438,545	2,272,918	5,732,796		5,732,796	114,458	5,847,254		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 Rockfrd

#0049270

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			13,527	13,527		13,527	87,089	100,616			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			174,416	174,416		174,416	125,022	299,438			32
33	Real Estate Taxes							123,537	123,537			33
34	Rent-Facility & Grounds			944,982	944,982		944,982	(934,348)	10,634			34
35	Rent-Equipment & Vehicles			30,314	30,314		30,314	1,886	32,200			35
36	Other (specify):* Mortgage Ins.							23,112	23,112			36
37	TOTAL Ownership			1,163,239	1,163,239		1,163,239	(573,702)	589,537			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		179,447		179,447		179,447		179,447			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			222,373	222,373		222,373		222,373			42
43	Other (specify):* See Att Sch 4A	95,229		448,743	543,972		543,972	(518,526)	25,446			43
44	TOTAL Special Cost Centers	95,229	179,447	671,116	945,792		945,792	(518,526)	427,266			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,116,562	617,992	4,107,273	7,841,827		7,841,827	(977,770)	6,864,057			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 Rockfrd

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			16,472	16,472	16,472		16,472			
	Radiology Expenses			8,974	8,974	8,974		8,974			
	Non-Allowable Expenses	95,229		423,297	518,526	518,526	(518,526)	0			
					0	0		0			
					0	0		0			
	TOTAL Other Special Cost Centers	95,229	0	448,743	543,972	543,972	(518,526)	25,446			

Facility Name & ID Number Rosewood Care Ctr of Rockfrd

0049270

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	(2,966)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,357)	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	(96,000)	30		9
10	Interest and Other Investment Income	(3,410)	32		10
11	Discounts, Allowances, Rebates & Refunds	(3,557)	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				17
18	Fines and Penalties				18
19	Entertainment	(28)	43		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,429)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(410,963)	43		24
25	Fund Raising, Advertising and Promotional	(4,336)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(240)	43		28
29	Other-Attach Schedule See Page 5A	(105,749)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (639,035)		\$	30

BHF USE ONLY					
48		49		50	51
					52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	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)	(338,735)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (338,735)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (977,770)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Care Ctr of Rockfrd

ID# 0049270

Report Period Beginning: 07/01/2014

Ending: 06/30/2015

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Eliminate Marketing Salary	\$ (95,229)	43	1
2	Eliminate Lobbying & PAC Dues	(1,318)	20	2
3	Miscellaneous Income Offset	214	21	3
4	Resident Reimbursements	(373)	43	4
5	Management Fee-Real Estate Entity	(7,200)	17	5
6	Mileage Reimbursement Related to Marketing	(1,843)	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
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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		(105,749)	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%	\$ 706	\$ 706	1
2	V	6 Maintenance		Bravo Nursing Home Services, Inc.	0.00%	25	25	2
3	V	7 Mgmt. Allocation of Benefits		Bravo Nursing Home Services, Inc.	0.00%	75	75	3
4	V	10 Nursing & Medical Records		Bravo Nursing Home Services, Inc.	0.00%	35,328	35,328	4
5	V	15 Mgmt. Allocation of Benefits		Bravo Nursing Home Services, Inc.	0.00%	3,753	3,753	5
6	V	17 Administrative	138,000	Bravo Nursing Home Services, Inc.	0.00%	12,839	(125,161)	6
7	V	19 Professional Services		Bravo Nursing Home Services, Inc.	0.00%	99	99	7
8	V	20 Dues, Fees, Subs & Promotions		Bravo Nursing Home Services, Inc.	0.00%	50	50	8
9	V	21 Clerical and General Office		Bravo Nursing Home Services, Inc.	0.00%	42,685	42,685	9
10	V	24 Travel and Seminar		Bravo Nursing Home Services, Inc.	0.00%	1,913	1,913	10
11	V	25 Other Admin. Staff Transport.		Bravo Nursing Home Services, Inc.	0.00%	1,690	1,690	11
12	V	26 Insurance-Prop./Liab./Malprac.		Bravo Nursing Home Services, Inc.	0.00%	185	185	12
13	V	27 Mgmt. Allocation of Benefits		Bravo Nursing Home Services, Inc.	0.00%	5,784	5,784	13
14	Total		\$ 138,000			\$ 105,132	\$ * (32,868)	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%	\$ 3,224	\$ 3,224	15
16	V	<u>2</u> Food		Midwest Administrative Services, Inc.	0.00%	1	1	16
17	V	<u>5</u> Utilities		Midwest Administrative Services, Inc.	0.00%	128	128	17
18	V	<u>6</u> Maintenance		Midwest Administrative Services, Inc.	0.00%	978	978	18
19	V	<u>7</u> Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	340	340	19
20	V	<u>10</u> Nursing and Medical Records		Midwest Administrative Services, Inc.	0.00%	8,853	8,853	20
21	V	<u>15</u> Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	934	934	21
22	V	<u>17</u> Administrative	189,355	Midwest Administrative Services, Inc.	0.00%	38,095	(151,260)	22
23	V	<u>19</u> Professional Services		Midwest Administrative Services, Inc.	0.00%	6,777	6,777	23
24	V	<u>20</u> Dues, Fees, Subs & Promotions		Midwest Administrative Services, Inc.	0.00%	6,345	6,345	24
25	V	<u>21</u> Clerical and General Office	61,107	Midwest Administrative Services, Inc.	0.00%	140,380	79,273	25
26	V	<u>24</u> Travel and Seminar		Midwest Administrative Services, Inc.	0.00%	2,965	2,965	26
27	V	<u>25</u> Other Admin. Staff Transport.		Midwest Administrative Services, Inc.	0.00%	1,687	1,687	27
28	V	<u>26</u> Insurance-Prop./Liab./Malprac.		Midwest Administrative Services, Inc.	0.00%	3,412	3,412	28
29	V	<u>27</u> Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	15,275	15,275	29
30	V	<u>30</u> Depreciation		Midwest Administrative Services, Inc.	0.00%	14,316	14,316	30
31	V	<u>32</u> Interest		Midwest Administrative Services, Inc.	0.00%	11,411	11,411	31
32	V	<u>34</u> Rent-Facility and Grounds		Midwest Administrative Services, Inc.	0.00%	10,634	10,634	32
33	V	<u>35</u> Rent-Equipment & Vehicles		Midwest Administrative Services, Inc.	0.00%	1,886	1,886	33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 250,462			\$ 267,641	\$ * 17,179	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	\$ 8,394	Claims Administration Services, LLC	0.00%	\$ 250	\$ (8,144)	15
16	V	21 Clerical and General Office		Claims Administration Services, LLC	0.00%	14,438	14,438	16
17	V	24 Travel and Seminar		Claims Administration Services, LLC	0.00%	832	832	17
18	V	25 Other Admin. Staff Transport.		Claims Administration Services, LLC	0.00%	436	436	18
19	V	26 Insurance-Prop./Liab./Malprac.		Claims Administration Services, LLC	0.00%	185	185	19
20	V	27 Mgmt. Allocation of Benefits		Claims Administration Services, LLC	0.00%	1,552	1,552	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		\$ 8,394			\$ 17,693	\$ * 9,299	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	5 Utilities	\$	Senior Living Services, Inc.	0.00%	\$ 266	\$	266	15
16	V	6 Maintenance	42,541	Senior Living Services, Inc.	0.00%	31,727		(10,814)	16
17	V	7 Mgmt. Allocation of Benefits		Senior Living Services, Inc.	0.00%	3,782		3,782	17
18	V	19 Professional Services		Senior Living Services, Inc.	0.00%	8		8	18
19	V	21 Clerical and General Office		Senior Living Services, Inc.	0.00%	651		651	19
20	V	24 Travel and Seminar		Senior Living Services, Inc.	0.00%	2,918		2,918	20
21	V	25 Other Admin. Staff Transport.		Senior Living Services, Inc.	0.00%	2,582		2,582	21
22	V	26 Insurance-Prop./Liab./Malprac.		Senior Living Services, Inc.	0.00%	761		761	22
23	V	30 Depreciation		Senior Living Services, Inc.	0.00%	1,048		1,048	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		\$ 42,541			\$ 43,743	\$ *	1,202	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%	\$ 149,634	\$ 149,634	15
16	V	20 Fees & Subscriptions		Bravo Holding Company	0.00%	57	57	16
17	V	21 Clerical and General Office		Bravo Holding Company	0.00%	764	764	17
18	V	24 Travel and Seminar		Bravo Holding Company	0.00%	251	251	18
19	V	25 Other Admin. Staff Transport.		Bravo Holding Company	0.00%	257	257	19
20	V	26 Insurance-Prop./Liab./Malprac.		Bravo Holding Company	0.00%	611	611	20
21	V	32 Interest	134,594	Bravo Holding Company	0.00%	16,086	(118,508)	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		\$ 134,594			\$ 167,660	\$ * 33,066	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	\$	Rockford Real Estate, LLC	0.00%	\$ 7,200	\$ 7,200
16	V	19 Professional Services		Rockford Real Estate, LLC	0.00%	6,126	6,126
17	V	20 Dues & Subscriptions		Rockford Real Estate, LLC	0.00%	300	300
18	V	21 Clerical and General Office		Rockford Real Estate, LLC	0.00%	6,571	6,571
19	V	26 Insurance-Prop./Liab./Malprac.		Rockford Real Estate, LLC	0.00%	8,269	8,269
20	V	30 Depreciation		Rockford Real Estate, LLC	0.00%	167,725	167,725
21	V	32 Interest	25	Rockford Real Estate, LLC	0.00%	235,554	235,529
22	V	33 Real Estate Taxes		Rockford Real Estate, LLC	0.00%	123,537	123,537
23	V	34 Rent-Facility and Grounds	944,982	Rockford Real Estate, LLC	0.00%		(944,982)
24	V	36 Mortgage Insurance		Rockford Real Estate, LLC	0.00%	23,112	23,112
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		\$ 945,007			\$ 578,394	\$ * (366,613)

* 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 Joliet, Inc.	Joliet, IL	Senior Living		Building Services	8
9			Bravo Care of Moline, Inc.	Moline, IL	Services, Inc.	St. Louis, MO	Company	9
10			Bravo Care of Northbrook, Inc.	Northbrook, IL	Bravo Team		Human Resources	10
11			Bravo Care of Peoria, Inc.	Peoria, 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					Rockford Real			14
15					Estate, LLC	Rockford, 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 Rockfrd # 0049270 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	57,156	4.97	9.94	Salary	3,834	L17, C7	1
2	Mark Yampol	CEO	Administrative	0.00	1,405,711	See Above	See Above	Consulting	94,289	L19, C7	2
3	Hillel Yampol	Owner	Administrative	0.00	45,112	4.97	9.94	Salary	3,026	L17, C7	3
4	Christene Rene Yampol	Owner	Administrative	0.00	67,484	4.97	9.94	Salary	4,526	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	\$ 105,675		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 Rockfrd

0049270 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	29,562	\$ 706	1
2	6	Maintenance	470,290	14	397		29,562	25	2
3	7	Mgmt. Allocation of Benefits	470,290	14	1,193		29,562	75	3
4	10	Nursing & Medical Records	470,290	14	562,016	562,016	29,562	35,328	4
5	15	Mgmt. Allocation of Benefits	470,290	14	59,699		29,562	3,753	5
6	17	Administrative	470,290	14	204,253	204,253	29,562	12,839	6
7	19	Professional Services	470,290	14	1,579		29,562	99	7
8	20	Dues, Fees, Subs & Promotions	470,290	14	786		29,562	50	8
9	21	Clerical and General Office	470,290	14	679,056	662,076	29,562	42,685	9
10	24	Travel and Seminar	470,290	14	30,438		29,562	1,913	10
11	25	Other Admin. Staff Transport.	470,290	14	26,889		29,562	1,690	11
12	26	Insurance-Prop./Liab./Malprac.	470,290	14	2,943		29,562	185	12
13	27	Mgmt. Allocation of Benefits	470,290	14	92,023		29,562	5,784	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		\$ 105,132	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Rockfrd

0049270 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	29,562	\$ 3,224	1
2	2	Food	470,290	14	13		29,562	1	2
3	5	Utilities	470,290	14	2,032		29,562	128	3
4	6	Maintenance	470,290	14	15,554		29,562	978	4
5	7	Mgmt. Allocation of Benefits	470,290	14	5,409		29,562	340	5
6	10	Nursing and Medical Records	470,290	14	140,839	140,839	29,562	8,853	6
7	15	Mgmt. Allocation of Benefits	470,290	14	14,860		29,562	934	7
8	17	Administrative	470,290	14	606,045	606,045	29,562	38,095	8
9	19	Professional Services	470,290	14	107,816		29,562	6,777	9
10	20	Dues, Fees, Subs & Promotions	470,290	14	100,942		29,562	6,345	10
11	21	Clerical and General Office	470,290	14	2,233,257	1,697,067	29,562	140,380	11
12	24	Travel and Seminar	470,290	14	47,164		29,562	2,965	12
13	25	Other Admin. Staff Transport.	470,290	14	26,845		29,562	1,687	13
14	26	Insurance-Prop./Liab./Malprac.	470,290	14	54,274		29,562	3,412	14
15	27	Mgmt. Allocation of Benefits	470,290	14	243,011		29,562	15,275	15
16	30	Depreciation	470,290	14	227,745		29,562	14,316	16
17	32	Interest	470,290	14	181,530		29,562	11,411	17
18	34	Rent-Facility and Grounds	470,290	14	169,173		29,562	10,634	18
19	35	Rent-Equipment & Vehicles	470,290	14	30,003		29,562	1,886	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 4,257,795	\$ 2,495,234		\$ 267,641	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Rockfrd

0049270 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	29,562	\$ 250	1
2	21	Clerical and General Office	Weighted Census	470,290	14	229,689	226,926	14,438	2
3	24	Travel and Seminar	Weighted Census	470,290	14	13,239	29,562	832	3
4	25	Other Admin. Staff Transport.	Weighted Census	470,290	14	6,938	29,562	436	4
5	26	Insurance-Prop./Liab./Malprac.	Weighted Census	470,290	14	2,943	29,562	185	5
6	27	Mgmt. Allocation of Benefits	Weighted Census	470,290	14	24,684	29,562	1,552	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		\$ 17,693	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Rockfrd

0049270 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	29,562	\$ 266	1
2	6	Maintenance	Weighted Census/Direct Exp	470,290	14	513,005	471,253	31,727	2
3	7	Mgmt. Allocation of Benefits	Weighted Census	470,290	14	60,169	29,562	3,782	3
4	19	Professional Services	Weighted Census	470,290	14	123	29,562	8	4
5	21	Clerical and General Office	Weighted Census	470,290	14	10,353	29,562	651	5
6	24	Travel and Seminar	Weighted Census	470,290	14	46,417	29,562	2,918	6
7	25	Other Admin. Staff Transport.	Weighted Census	470,290	14	41,082	29,562	2,582	7
8	26	Insurance-Prop./Liab./Malprac.	Weighted Census	470,290	14	12,112	29,562	761	8
9	30	Depreciation	Weighted Census	470,290	14	16,668	29,562	1,048	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		\$ 43,743	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Rockfrd

0049270 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	Weighted Census	470,290	14	2,380,463	29,562	\$ 149,634	1
2	20	Fees & Subscriptions	Weighted Census	470,290	14	901	29,562	57	2
3	21	Clerical and General Office	Weighted Census	470,290	14	12,160	29,562	764	3
4	24	Travel and Seminar	Weighted Census	470,290	14	3,989	29,562	251	4
5	25	Other Admin. Staff Transport.	Weighted Census	470,290	14	4,094	29,562	257	5
6	26	Insurance-Prop./Liab./Malprac.	Weighted Census	470,290	14	9,723	29,562	611	6
7	32	Interest	Weighted Census	470,290	14	255,901	29,562	16,086	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	\$	\$ 167,660	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	\$73,916.21	11/1/04	\$ 4,941,300	\$ 9,757,135	12/1/39	0.0470	\$ 230,695	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	39,822	6					
7	Bravo Holding Co.)											7					
8												8					
9	TOTAL Facility Related				\$73,916.21		\$ 4,941,300	\$ 9,757,135			\$ 270,517	9					
B. Non-Facility Related*																	
10							Less: Interest Income Offset				(3,435)	10					
11							Amortization Expense				4,859	11					
12							Allocated from Mgmt Co's				27,497	12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$ 28,921	14					
15	TOTALS (line 9+line14)						\$ 4,941,300	\$ 9,757,135			\$ 299,438	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 23,112 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.)

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 2014 report.			\$	123,537	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		\$	121,548	2										
3. Under or (over) accrual (line 2 minus line 1).			\$	(1,989)	3										
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	125,526	4										
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5										
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6										
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	123,537	7										
Real Estate Tax History:															
Real Estate Tax Bill for Calendar Year:	2010	115,223	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2014 \$</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2014 \$	14	PLUS APPEAL COST FROM LINE 5 \$	15	LESS REFUND FROM LINE 6 \$	16	AMOUNT TO USE FOR RATE CALCULATION \$
FOR BHF USE ONLY															
13	FROM R. E. TAX STATEMENT FOR 2014 \$														
14	PLUS APPEAL COST FROM LINE 5 \$														
15	LESS REFUND FROM LINE 6 \$														
16	AMOUNT TO USE FOR RATE CALCULATION \$														
Taxes Paid-2013	2011	119,752	9												
Taxes Paid-2014	2012	118,352	10												
Total Taxes Paid	2013	121,115	11												
	2014	121,982	12												
Accrual based on prior year tax bill.															

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.

SEE ACCOUNTANTS' COMPILATION REPORT

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rosewood Care Ctr of Rockfrd COUNTY Winnebago
 FACILITY IDPH LICENSE NUMBER 0049270
 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>12-34-102-022</u>	<u>Rosewood Sub</u>	\$ <u>121,981.96</u>	\$ <u>121,981.96</u>
2. _____	<u>Pt NW 1/4 Sec 34-44-2 Lot 1</u>	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>121,981.96</u></u>	\$ <u><u>121,981.96</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: 41,042 B. General Construction Type: Exterior Stucco 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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>	<u>41,042</u>	<u>2013</u>	<u>\$ 262,474</u>	1
2					2
3	TOTALS	41,042		\$ 262,474	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	2013	1996	\$ 2,690,005	\$	40	\$ 67,250	\$ 67,250	\$ 100,875	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Building Improvements - Real Estate Entity									9
10										10
11	Doors		2014	4,774		40	80	80	80	11
12	Doors		2015	8,790		40	85	85	85	12
13	Repair Damaged Roof from Hail Storm		2015	9,520		40	119	119	119	13
14	Seal Coating		2015	4,557		25	91	91	91	14
15	Install (2) Fire Dampers in Mechanical Room		2015	3,275		10	82	82	82	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

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	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		\$	\$		\$	\$	\$	37
38								38
39	2008	21,667	2,437	7	2,437		21,667	39
40	2008	5,454	779	7	779		5,194	40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 2,748,042	\$ 3,216		\$ 70,923	\$ 67,707	\$ 128,193	70

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	\$ 51,556	\$ 10,311	\$ 10,311	\$	5	\$ 21,804	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Allocated from Mgmt Co/Real Estate Entity	41,798		19,382	19,382		5,946	74
75	TOTALS	\$ 93,354	\$ 10,311	\$ 29,693	\$ 19,382		\$ 27,750	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)	\$ 3,103,870	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 13,527	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 100,616	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 87,089	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 155,943	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 Rockfrd

0049270

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				10,634			6
7	TOTAL				\$ 10,634			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. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

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: \$ 32,200 Description: Offsite Storage - \$4,189, Medical Equipment - \$26,125, Home Office Allocation - \$1,886

(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 Rockfrd # 0049270 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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	6,224	\$ 248,957	\$	6,224	\$ 248,957	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		491	26,538		491	26,538	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		8,486	339,427	1,287	8,486	340,714	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				179,447		179,447	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			\$	15,201	\$ 614,922	\$ 180,734	15,201	\$ 795,656	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 Rockfrd

0049270

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	\$ (63,923)	\$ (63,450)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>719,000</u>)	1,294,684	1,294,684	3
4	Supply Inventory (priced at <u>Cost</u>)	4,041	4,041	4
5	Short-Term Investments			5
6	Prepaid Insurance	25,858	29,334	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,260,660	\$ 1,264,609	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		262,474	13
14	Buildings, at Historical Cost		2,713,089	14
15	Leasehold Improvements, at Historical Cost	27,121	34,953	15
16	Equipment, at Historical Cost	51,556	93,354	16
17	Accumulated Depreciation (book methods)	(48,665)	(155,943)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		96,578	21
22	Other Long-Term Assets (spec <u>Loan Fees</u>)		189,021	22
23	Other(specify): <u>Deposits</u>	2,000	2,000	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 32,012	\$ 3,235,526	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,292,672	\$ 4,500,135	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 680,716	\$ 695,227	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	159,037	159,037	30
31	Accrued Taxes Payable (excluding real estate taxes)	38,111	38,111	31
32	Accrued Real Estate Taxes(Sch.IX-B)		125,526	32
33	Accrued Interest Payable		5,462	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	3,529	3,529	35
Other Current Liabilities(specify):				
36	<u>Accrued Expenses</u>	481,116	492,316	36
37	<u>Accrued Rent</u>	583,173	(1,509)	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,945,682	\$ 1,517,699	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,757,135	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Due to Bravo Holding Company</u>	2,943,250	2,943,250	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,943,250	\$ 12,700,385	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,888,932	\$ 14,218,084	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,596,260)	\$ (9,717,949)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,292,672	\$ 4,500,135	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,417,413)	1
2	Restatements (describe):		2
3	Prior period post closing adjustments	(19,110)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,436,523)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,159,737)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,159,737)	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)	\$ (3,596,260)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 7,765,845	1
2	Discounts and Allowances for all Levels	(1,436,436)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,329,409	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	295,434	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 295,434	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	1,525	13
14	Non-Patient Meals	1,667	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	45,928	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 49,195	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	3,410	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,410	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Attached Schedule 19A</u>	4,642	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,642	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,682,090	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,076,439	31
32	Health Care	3,380,888	32
33	General Administration	1,275,469	33
B. Capital Expense			
34	Ownership	1,163,239	34
C. Ancillary Expense			
35	Special Cost Centers	723,419	35
36	Provider Participation Fee	222,373	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,841,827	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,159,737)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,159,737)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,952,447	44
45	Private Pay - Net Inpatient Revenue	2,066,506	45
46	Medicare - Net Inpatient Revenue	1,893,695	46
47	Other-(specify) <u>Insurance/Managed Care</u>	416,761	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,329,409	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 Rockfrd

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

Schedule 19A

Other Revenue:

Vending Income	1,299
Vendor Discount	3,557
Miscellaneous	(214)
	<hr/>
Total Other Revenue	<u>4,642</u>

Facility Name & ID Number Rosewood Care Ctr of Rockfrd

0049270

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	2,045	2,311	\$ 69,778	\$ 30.19	1
2	Assistant Director of Nursing	1,718	1,932	50,992	26.39	2
3	Registered Nurses	29,724	31,532	836,876	26.54	3
4	Licensed Practical Nurses	16,185	17,382	387,036	22.27	4
5	CNAs & Orderlies	68,803	72,871	753,329	10.34	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,091	2,283	27,528	12.06	8
9	Activity Director	2,142	2,308	29,028	12.58	9
10	Activity Assistants	3,027	3,265	27,881	8.54	10
11	Social Service Workers	4,164	4,475	55,996	12.51	11
12	Dietician					12
13	Food Service Supervisor	2,072	2,191	39,290	17.93	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,617	24,523	202,211	8.25	15
16	Dishwashers					16
17	Maintenance Workers	2,082	2,242	36,361	16.22	17
18	Housekeepers	735	1,542	18,114	11.75	18
19	Laundry	323	611	5,627	9.21	19
20	Administrator	2,419	2,774	100,510	36.23	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,065	9,993	102,523	10.26	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	4,369	4,659	49,965	10.72	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Sch 20A</u>	13,077	14,137	323,517	22.88	33
34	TOTAL (lines 1 - 33)	186,658	201,031	\$ 3,116,562 *	\$ 15.50	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	\$ 16,385	L1, C3	35
36	Medical Director	Monthly	9,900	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,152	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	2,600	L11, C3	44
45	Social Service Consultant	Monthly	2,600	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 39,637		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	87	\$ 3,772	L10, C3	50
51	Licensed Practical Nurses	120	4,146	L10, C3	51
52	Certified Nurse Assistants/Aides	1,209	24,412	L10, C3	52
53	TOTAL (lines 50 - 52)	1,416	\$ 32,330		53

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Care Ctr of Rockfrd

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	3,193	3,558	85,020	23.90
Case Manager	3,666	3,801	106,027	27.89
Ward Clerk	1,884	2,048	37,241	18.18
Marketing	4,334	4,730	95,229	20.13
TOTAL	<u>13,077</u>	<u>14,137</u>	<u>323,517</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	
Bart Becker	Administrator	0	\$ 71,786	Workers' Compensation Insurance	\$ 86,256	IDPH License Fee	\$	
LuAnn Brannum	Administrator	0	28,724	Unemployment Compensation Insurance	41,515	Advertising: Employee Recruitment	896	
				FICA Taxes	236,202	Health Care Worker Background Check		
				Employee Health Insurance	38,880	(Indicate # of checks performed <u>432</u>)	4,762	
				Employee Meals		<u>Patient Background Checks</u>		
				Illinois Municipal Retirement Fund (IMRF)*				
				Employee Relations	2,851	Misc. Dues/Subscriptions/Fees	707	
				Employee Uniforms	603	IHCA Dues	2,117	
				Employee Physicals	2,032	Misc. Licenses	998	
				Employee Drug Tests	298	Home Office Allocation	6,752	
				Tuition Reimbursement	646	Less: Public Relations Expense	()	
				401K Expense	2,481	Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
\$ 100,510				\$ 411,764		\$ 16,232		
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
Mgmt Fees-Bravo Nursing Home Svc-See Pg 6, Elim on P 3, C 7			\$ 138,000	N/A			Out-of-State Travel	\$
Mgmt Fees-Midwest Admin Svc-See Pg 6, Elim on P 3, C 7			189,355					
							In-State Travel	72
							Home Office Allocation	8,879
							Seminar Expense	80
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			Entertainment Expense (agree to Sch. V, line 24, col. 8)	
\$ 327,355				\$			\$ 9,031	
C. Professional Services								
Vendor/Payee	Type		Amount					
Hochschild, Bloom & Company	Accountant/Consultant		\$ 3,120					
WestLaw	Computer Consulting		39,771					
Odessa Healthcare	Consultant		75,303					
Claims Administration Services, Inc.	Related Party Legal Fees		8,394					
Daniel Maher	Legal Fees		6,733					
Mulherin, Rehfeldt & Varchetto	Legal Fees		2,970					
Clerk of the Circuit Court	Court Filing Fee		287					
Deb Fisher	Court Reporting Fee		714					
Hamlin & Burton Liability Manager	Insurance Consultant		(500)					
Various	Various below \$200		236					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)								
\$ 137,028								

* 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 Rockfrd

0049270

Report Period Beginning: 07/01/2014 Ending: 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. 2,117 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. \$ 51,059 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. \$ 222,373
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (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. \$ 2,966
- (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.