



Facility Name & ID Number Rosewood Care Center Of Rockford

# 0049270 Report Period Beginning: 07/01/15 Ending: 06/30/16

III. STATISTICAL DATA

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

	1	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	43,920	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	43,920	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	15,549	5,516	8,039	29,104	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,549	5,516	8,039	29,104	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.27%

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)

N/A

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

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 12/01/07

J. Was the facility purchased or leased after January 1, 1978?

YES  Date 12/01/07 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 6,040

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: 06/30/16 Fiscal Year: 06/30/16

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

Facility Name & ID Number Rosewood Care Center Of Rockford # 0049270 Report Period Beginning: 07/01/15 Ending: 06/30/16

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 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
	<b>A. General Services</b>										
1	Dietary	28,769	3,597	349,640	382,006		382,006	408	382,414		1
2	Food Purchase		223,624		223,624		223,624	(9,501)	214,123		2
3	Housekeeping		17,985	173,975	191,960		191,960		191,960		3
4	Laundry			115,983	115,983		115,983		115,983		4
5	Heat and Other Utilities			127,509	127,509		127,509	(7,243)	120,266		5
6	Maintenance	40,266	5,813	197,091	243,170		243,170	(22,461)	220,709		6
7	Other (specify):*							2,291	2,291		7
8	<b>TOTAL General Services</b>	<b>69,035</b>	<b>251,019</b>	<b>964,198</b>	<b>1,284,252</b>		<b>1,284,252</b>	<b>(36,506)</b>	<b>1,247,746</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	1,834,611	268,476	547,356	2,650,443		2,650,443	25,854	2,676,297		10
10a	Therapy	55,064	2,279		57,343		57,343		57,343		10a
11	Activities	56,730	4,204	2,200	63,134		63,134		63,134		11
12	Social Services	67,764		2,200	69,964		69,964		69,964		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							2,540	2,540		15
16	<b>TOTAL Health Care and Programs</b>	<b>2,014,169</b>	<b>274,959</b>	<b>551,756</b>	<b>2,840,884</b>		<b>2,840,884</b>	<b>28,394</b>	<b>2,869,278</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	97,276		345,014	442,290		442,290	(298,619)	143,671		17
18	Directors Fees										18
19	Professional Services			102,347	102,347		102,347	(15,189)	87,158		19
20	Dues, Fees, Subscriptions & Promotions			22,095	22,095		22,095	(486)	21,609		20
21	Clerical & General Office Expenses	119,980	29,503	688,569	838,052		838,052	(522,244)	315,808		21
22	Employee Benefits & Payroll Taxes			308,128	308,128		308,128		308,128		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,068	1,068		1,068	849	1,917		24
25	Other Admin. Staff Transportation			2,298	2,298		2,298	6,234	8,532		25
26	Insurance-Prop.Liab.Malpractice			62,859	62,859		62,859	13,402	76,261		26
27	Other (specify):*							20,458	20,458		27
28	<b>TOTAL General Administration</b>	<b>217,256</b>	<b>29,503</b>	<b>1,532,378</b>	<b>1,779,137</b>		<b>1,779,137</b>	<b>(795,593)</b>	<b>983,544</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,300,460</b>	<b>555,481</b>	<b>3,048,332</b>	<b>5,904,273</b>		<b>5,904,273</b>	<b>(803,706)</b>	<b>5,100,567</b>		<b>29</b>

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

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

Facility Name &amp; ID Number

Rosewood Care Center Of Rockford

#0049270

Report Period Beginning:

07/01/15

Ending:

06/30/16

## 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	
	<b>D. Ownership</b>											
30	Depreciation			10,571	10,571		10,571	83,893	94,464			30
31	Amortization of Pre-Op. & Org.							0	0			31
32	Interest			226,120	226,120		226,120	468,881	695,001			32
33	Real Estate Taxes							124,422	124,422			33
34	Rent-Facility & Grounds			957,343	957,343		957,343	(940,506)	16,837			34
35	Rent-Equipment & Vehicles							19	19			35
36	Other (specify):*			15,630	15,630		15,630	33,019	48,649			36
37	<b>TOTAL Ownership</b>			1,209,664	1,209,664		1,209,664	(230,273)	979,391			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		312,455	796,851	1,109,306		1,109,306		1,109,306			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			205,308	205,308		205,308		205,308			42
43	Other (specify):*	83,526		1,940	85,466		85,466	(85,466)				43
44	<b>TOTAL Special Cost Centers</b>	83,526	312,455	1,004,099	1,400,080		1,400,080	(85,466)	1,314,614			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	2,383,986	867,936	5,262,095	8,514,017		8,514,017	(1,119,445)	7,394,572			45

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

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,444)	02		4
5	Telephone, TV & Radio in Resident Rooms	(7,492)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(96,515)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(424)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(15)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(452,043)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(232)	20		28
29	Other-Attach Schedule	(356,946)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (915,111)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(204,334)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (204,334)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (1,119,445)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

<b>BHF USE ONLY</b>							
48		49		50		51	52

**Rosewood Care Center Of Rockford**

ID# 0049270

Report Period Beginning: 07/01/15

Ending: 06/30/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Bank Charges	\$ (2,909)	21	1
2	Vending Income	(1,306)	02	2
3	PAC Dues	(2,588)	20	3
4	Midcap Credit Fees	(15,630)	36	4
5	Hospice AR Reserve	(187,604)	21	5
6	Marketing Salary	(83,526)	43	6
7	Marketing Expense	(1,940)	43	7
8	Resident Reimbursement	(115)	10	8
9	Vendor Discount	(6,327)	02	9
10	Miscellaneous Income	(3,255)	21	10
11	Vendor Late Charges	(17,093)	21	11
12	Marketing Travel	(1,440)	25	12
13	Bldg. Co. - Audit Fees	(4,100)	19	13
14	Bldg. Co. - Pro. Fees	(883)	19	14
15	Bldg.Co.- Bank Fees	(13,307)	21	15
16	Bldg. Co.-Amortization	(4,859)	31	16
17	Capitalized R& M	(6,303)	06	17
18	Non Allowable Legal Fees	(3,761)	19	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	<b>Total</b>	(356,946)		49

Rosewood Care Center Of Rockford

Report Period Beginning:                     07/01/15                      
 Ending:   06/30/16                    

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

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Center Of Rockford# 0049270

Report Period Beginning:

07/01/15

Ending:

06/30/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				408								408	1
2	Food Purchase	(9,501)											(9,501)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(7,492)		140				110					(7,243)	5
6	Maintenance	(6,303)		84				(16,243)					(22,461)	6
7	Other (specify):*				43			2,247					2,291	7
8	<b>TOTAL General Services</b>	<b>(23,296)</b>		<b>224</b>	<b>451</b>			<b>(13,885)</b>					<b>(36,506)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(115)			25,969								25,854	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				2,540								2,540	15
16	<b>TOTAL Health Care and Programs</b>	<b>(115)</b>			<b>28,509</b>								<b>28,394</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(207,014)	(97,879)	6,273							(298,619)	17
18	Directors Fees													18
19	Professional Services	(8,744)	4,983	101	73	16,697	(28,354)	53					(15,189)	19
20	Fees, Subscriptions & Promotions	(2,820)		2,050	2	214	17	51					(486)	20
21	Clerical & General Office Expenses	(676,226)	20,507	128,763	409	289	3,821	193					(522,244)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			421	149	258	22						849	24
25	Other Admin. Staff Transportation	(1,440)		2,130	2,692	1,304	235	1,314					6,234	25
26	Insurance-Prop.Liab.Malpractice		9,270	3,691				442					13,402	26
27	Other (specify):*			17,005	3,228		225						20,458	27
28	<b>TOTAL General Administration</b>	<b>(689,230)</b>	<b>34,760</b>	<b>(52,853)</b>	<b>(91,326)</b>	<b>25,036</b>	<b>(24,033)</b>	<b>2,053</b>					<b>(795,593)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(712,641)</b>	<b>34,760</b>	<b>(52,629)</b>	<b>(62,366)</b>	<b>25,036</b>	<b>(24,033)</b>	<b>(11,832)</b>					<b>(803,706)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Center Of Rockford # 0049270 Report Period Beginning: 07/01/15 Ending: 06/30/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	(96,515)	165,985	13,930				492					83,893	30
31	Amortization of Pre-Op. & Org.	(4,859)	4,859										0	31
32	Interest		454,038	15,941		(1,098)							468,881	32
33	Real Estate Taxes		124,422										124,422	33
34	Rent-Facility & Grounds		(953,461)	12,955									(940,506)	34
35	Rent-Equipment & Vehicles				8	5		5					19	35
36	Other (specify):*	(15,630)	48,649										33,019	36
37	<b>TOTAL Ownership</b>	<b>(117,004)</b>	<b>(155,508)</b>	<b>42,826</b>	<b>8</b>	<b>(1,092)</b>		<b>497</b>					<b>(230,273)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(85,466)											(85,466)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(85,466)</b>											<b>(85,466)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(915,111)</b>	<b>(120,749)</b>	<b>(9,803)</b>	<b>(62,357)</b>	<b>23,944</b>	<b>(24,033)</b>	<b>(11,335)</b>					<b>(1,119,445)</b>	<b>45</b>

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See 6 Supplemental		See 6 Supplemental		See 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	34 RENTAL INCOME	\$ 953,461	Rockford Real Estate	100.00%	\$	\$ (953,461)	1
2	V	32 INT INCOME - ESCROW	35	Rockford Real Estate	100.00%		(35)	2
3	V	19 AUDIT FEES - HB&CO		Rockford Real Estate	100.00%	4,100	4,100	3
4	V	19 PROFESSIONAL FEES		Rockford Real Estate	100.00%	883	883	4
5	V	21 BANK CHARGES		Rockford Real Estate	100.00%	13,307	13,307	5
6	V	32 INT EXPENSE - HUD MORTGAGE		Rockford Real Estate	100.00%	454,073	454,073	6
7	V	36 INT EXPENSE - HUD MIP		Rockford Real Estate	100.00%	48,649	48,649	7
8	V	33 REAL ESTATE TAX		Rockford Real Estate	100.00%	124,422	124,422	8
9	V	30 DEPRECIATION		Rockford Real Estate	100.00%	165,985	165,985	9
10	V	31 AMORTIZATION LOAN FEE		Rockford Real Estate	100.00%	4,859	4,859	10
11	V	21 BASE ADMIN FEE (PAGE 6A)		Rockford Real Estate	100.00%	7,200	7,200	11
12	V	26 INSURANCE EXPENSE - PROPERTY		Rockford Real Estate	100.00%	9,270	9,270	12
13	V							13
14	Total		\$ 953,496			\$ 832,747	\$ * (120,749)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 UTILITIES	\$	MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	\$ 140	\$	140	15
16	V	6 MAINTENANCE EXPENSE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	84		84	16
17	V	19 PROFESSIONAL FEES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	101		101	17
18	V	20 DUES, SUBSCRIPTIONS, LICENSES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	2,050		2,050	18
19	V	21 OFFICE SALARIES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	107,069		107,069	19
20	V	21 OFFICE EXPENSES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	28,895		28,895	20
21	V	24 SEMINAR		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	421		421	21
22	V	25 TRAVEL EXPENSE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	2,130		2,130	22
23	V	26 INSURANCE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	3,691		3,691	23
24	V	27 EMPLOYEE BENEFITS		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	17,005		17,005	24
25	V	30 DEPRECIATION		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	13,930		13,930	25
26	V	32 INTEREST		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	15,941		15,941	26
27	V	34 BUILDING RENT		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	12,955		12,955	27
28	V								28
29	V	17 ADMINISTRATIVE FEE	207,014	MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%			(207,014)	29
30	V	21 ADMINISTRATIVE FEE (BLDG CO)	7,200	MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%			(7,200)	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 214,214			\$ 204,411	\$ *	(9,803)	39

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1		BRAVO NURSING HOME SERVICES, INC.	100.00%	\$ 408	\$	408	15
16	V	7		BRAVO NURSING HOME SERVICES, INC.	100.00%	43		43	16
17	V	10		BRAVO NURSING HOME SERVICES, INC.	100.00%	25,969		25,969	17
18	V	15		BRAVO NURSING HOME SERVICES, INC.	100.00%	2,540		2,540	18
19	V	17		BRAVO NURSING HOME SERVICES, INC.	100.00%	40,121		40,121	19
20	V	19		BRAVO NURSING HOME SERVICES, INC.	100.00%	73		73	20
21	V	20		BRAVO NURSING HOME SERVICES, INC.	100.00%	2		2	21
22	V	21		BRAVO NURSING HOME SERVICES, INC.	100.00%	409		409	22
23	V	24		BRAVO NURSING HOME SERVICES, INC.	100.00%	149		149	23
24	V	25		BRAVO NURSING HOME SERVICES, INC.	100.00%	2,692		2,692	24
25	V	27		BRAVO NURSING HOME SERVICES, INC.	100.00%	3,228		3,228	25
26	V	35		BRAVO NURSING HOME SERVICES, INC.	100.00%	8		8	26
27	V								27
28	V	17	138,000	BRAVO NURSING HOME SERVICES, INC.	100.00%			(138,000)	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 138,000			\$ 75,643	\$ *	(62,357)	39

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	17 CONSULTING FEES	\$	BRAVO HOLDING COMPANY	100.00%	\$ 6,273	\$	6,273	15
16	V	19 PROFESSIONAL FEES		BRAVO HOLDING COMPANY	100.00%	16,697		16,697	16
17	V	20 DUES & SUBSCRIPTIONS		BRAVO HOLDING COMPANY	100.00%	214		214	17
18	V	21 OFFICE EXPENSE		BRAVO HOLDING COMPANY	100.00%	289		289	18
19	V	24 SEMINAR EXPENSE		BRAVO HOLDING COMPANY	100.00%	258		258	19
20	V	25 AUTO & TRAVEL EXPENSE		BRAVO HOLDING COMPANY	100.00%	1,304		1,304	20
21	V	32 INTEREST		BRAVO HOLDING COMPANY	100.00%	(1,098)		(1,098)	21
22	V	35 AUTO RENTAL		BRAVO HOLDING COMPANY	100.00%	5		5	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 23,944	\$ *	23,944	39

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	19 PROFESSIONAL FEES	\$	CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	\$ 108	\$	108	15
16	V	20 LICENSES		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	17		17	16
17	V	21 OFFICE SALARIES		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	3,742		3,742	17
18	V	21 OFFICE EXPENSE		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	79		79	18
19	V	24 SEMINAR		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	22		22	19
20	V	25 AUTO / TRAVEL EXPENSE		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	235		235	20
21	V	27 EMPLOYEE BENEFITS		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	225		225	21
22	V								22
23	V	19 PROFESSIONAL FEES	28,462	CLAIMS ADMINISTRATION SERVICES, LLC	100.00%			(28,462)	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		\$ 28,462			\$ 4,429	\$ *	(24,033)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 UTILITIES	\$	SENIOR LIVING SERVICES, INC.	100.00%	\$ 110	\$	110	15
16	V	6 MAINTENANCE SALARY		SENIOR LIVING SERVICES, INC.	100.00%	15,851		15,851	16
17	V	6 MAINTENANCE EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	1,608		1,608	17
18	V	7 MAINTENANCE BENEFITS		SENIOR LIVING SERVICES, INC.	100.00%	2,247		2,247	18
19	V	19 PROFESSIONAL FEES		SENIOR LIVING SERVICES, INC.	100.00%	53		53	19
20	V	20 LICENSES		SENIOR LIVING SERVICES, INC.	100.00%	51		51	20
21	V	21 OFFICE EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	193		193	21
22	V	25 AUTO / TRAVEL EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	1,314		1,314	22
23	V	26 INSURANCE		SENIOR LIVING SERVICES, INC.	100.00%	442		442	23
24	V	30 DEPRECIATION		SENIOR LIVING SERVICES, INC.	100.00%	492		492	24
25	V	35 AUTO LEASE		SENIOR LIVING SERVICES, INC.	100.00%	5		5	25
26	V	6 MAINTENANCE SUPPLIES		SENIOR LIVING SERVICES, INC.	100.00%	166		166	26
27	V								27
28	V	6 MAINTENANCE SERVICES	33,868	SENIOR LIVING SERVICES, INC.	100.00%			(33,868)	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		\$ 33,868			\$ 22,533	\$ *	(11,335)	39

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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





Facility Name &amp; ID Number

Rosewood Care Center Of Rockford

# 0049270

Report Period Beginning:

07/01/15

Ending:

06/30/16

## VII. RELATED PARTIES (continued)

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

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

	1 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	Hillel Yampol	Shareholder	Administrative	50.00%	See Attached	1.25	6.25%	Alloc. Salary	\$ 1,423	17-7	1	
2	Mark Yampol	Relative	Administrative	0	See Attached	1.25	6.25%	Alloc. Fee	6,273	17-7	2	
3											3	
4											4	
5											5	
6											6	
7											7	
8											8	
9											9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 7,696		13	

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

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

Facility Name & ID Number Rosewood Care Center Of Rockford

# 0049270

Report Period Beginning:

07/01/15

Ending: 06/30/16

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	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
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Rosewood Care Center Of Rockford

# 0049270

Report Period Beginning:

07/01/15

Ending: 06/30/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization 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

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	PAT. DAYS	463,927	14	\$ 2,224	\$ 29,104	\$ 140	1	
2	6	MAINTENANCE EXPENSE	PAT. DAYS	463,927	14	1,345	29,104	84	2	
3	19	PROFESSIONAL FEES	PAT. DAYS	463,927	14	1,614	29,104	101	3	
4	20	DUES, SUBSCRIPTIONS, LICEN	PAT. DAYS	463,927	14	32,685	29,104	2,050	4	
5	21	OFFICE SALARIES	PAT. DAYS	463,927	14	1,706,712	1,706,712	29,104	107,069	5
6	21	OFFICE EXPENSES	PAT. DAYS	463,927	14	460,588	29,104	28,895	6	
7	24	SEMINAR	PAT. DAYS	463,927	14	6,706	29,104	421	7	
8	25	TRAVEL EXPENSE	PAT. DAYS	463,927	14	33,946	29,104	2,130	8	
9	26	INSURANCE	PAT. DAYS	463,927	14	58,834	29,104	3,691	9	
10	27	EMPLOYEE BENEFITS	PAT. DAYS	463,927	14	271,068	29,104	17,005	10	
11	30	DEPRECIATION	PAT. DAYS	463,927	14	222,055	29,104	13,930	11	
12	32	INTEREST	PAT. DAYS	463,927	14	254,102	29,104	15,941	12	
13	34	BUILDING RENT	PAT. DAYS	463,927	14	206,500	29,104	12,955	13	
14									14	
15									15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 3,258,379	\$ 1,706,712	\$ 204,412	25	

Facility Name & ID Number Rosewood Care Center Of Rockford

# 0049270

Report Period Beginning:

07/01/15

Ending: 06/30/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization BRAVO NURSING HOME SERVICES, INC.  
 Street Address 11701 BORMAN DRIVE, SUITE 315  
 City / State / Zip Code ST. LOUIS, MO 63146  
 Phone Number ( 314) 994-9070  
 Fax Number ( 314) 994-9912

1	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 SALARY	PAT. DAYS	463,927	14	\$ 6,505	\$ 29,104	\$ 408	1
2	7	DIETARY BENEFITS	PAT. DAYS	463,927	14	687	29,104	43	2
3	10	CORPORATE RN SALARIES	PAT. DAYS	463,927	14	413,960	29,104	25,969	3
4	15	CORPORATE RN SALARIES BE	PAT. DAYS	463,927	14	40,484	29,104	2,540	4
5	17	ADMINISTRATIVE SALARIES	PAT. DAYS	463,927	14	639,544	29,104	40,121	5
6	19	PROFESSIONAL FEES	PAT. DAYS	463,927	14	1,170	29,104	73	6
7	20	DUES & SUBSCRIPTIONS	PAT. DAYS	463,927	14	27	29,104	2	7
8	21	OFFICE EXPENSES	PAT. DAYS	463,927	14	6,517	29,104	409	8
9	24	SEMINAR & LODGING EXPEN	PAT. DAYS	463,927	14	2,370	29,104	149	9
10	25	AUTO EXPENSE	PAT. DAYS	463,927	14	42,910	29,104	2,692	10
11	27	ADMINISTRATIVE & OFFICE I	PAT. DAYS	463,927	14	51,458	29,104	3,228	11
12	35	AUTO LEASE	PAT. DAYS	463,927	14	133	29,104	8	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,205,766	\$ 1,060,009	\$ 75,642	25

Facility Name & ID Number Rosewood Care Center Of Rockford

# 0049270

Report Period Beginning:

07/01/15

Ending: 06/30/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization BRAVO HOLDING COMPANY  
 Street Address 11701 BORMAN DRIVE, SUITE 315  
 City / State / Zip Code ST. LOUIS, MO 63146  
 Phone Number ( 314) 994-9070  
 Fax Number ( 314) 994-9912

1	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	17	CONSULTING FEES	PATIENT DAYS	463,927	14	\$ 100,000	\$ 29,104	\$ 6,273	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	463,927	14	266,160	29,104	16,697	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	463,927	14	3,410	29,104	214	3
4	21	OFFICE EXPENSE	PATIENT DAYS	463,927	14	4,609	29,104	289	4
5	24	SEMINAR EXPENSE	PATIENT DAYS	463,927	14	4,112	29,104	258	5
6	25	AUTO & TRAVEL EXPENSE	PATIENT DAYS	463,927	14	20,788	29,104	1,304	6
7	32	INTEREST	PATIENT DAYS	463,927	14	(17,495)	29,104	(1,098)	7
8	35	AUTO RENTAL	PATIENT DAYS	463,927	14	85	29,104	5	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 381,668	\$	\$ 23,942	25

Facility Name & ID Number Rosewood Care Center Of Rockford

# 0049270

Report Period Beginning:

07/01/15

Ending: 06/30/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization CLAIMS ADMINISTRATION SERVICES, LLC  
 Street Address 11701 BORMAN DRIVE, SUITE 315  
 City / State / Zip Code ST. LOUIS, MO 63146  
 Phone Number ( 314) 994-9070  
 Fax Number ( 314) 994-9912

1	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 FEES	ACTUAL FEES	667,999	13	\$ 6,309	\$ 11,462	\$ 108	1
2	20	LICENSES	ACTUAL FEES	667,999	13	1,000	11,462	17	2
3	21	OFFICE SALARIES	ACTUAL FEES	667,999	13	218,085	218,085	3,742	3
4	21	OFFICE EXPENSE	ACTUAL FEES	667,999	13	4,612	11,462	79	4
5	24	SEMINAR	ACTUAL FEES	667,999	13	1,281	11,462	22	5
6	25	AUTO / TRAVEL EXPENSE	ACTUAL FEES	667,999	13	13,694	11,462	235	6
7	27	EMPLOYEE BENEFITS	ACTUAL FEES	667,999	13	13,112	11,462	225	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 258,092	\$ 218,085	\$ 4,428	25

Facility Name & ID Number Rosewood Care Center Of Rockford

# 0049270

Report Period Beginning:

07/01/15

Ending: 06/30/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization SENIOR LIVING SERVICES, INC.  
 Street Address 11701 BORMAN DRIVE, SUITE 315  
 City / State / Zip Code ST. LOUIS, MO 63146  
 Phone Number ( 314) 994-9070  
 Fax Number ( 314) 994-9912

1	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	ACTUAL FEES	14	\$ 3,017	\$	33,868	\$ 110	1
2	6	MAINTENANCE SALARY	ACTUAL FEES	14	435,123	435,123	33,868	15,851	2
3	6	MAINTENANCE EXPENSE	ACTUAL FEES	14	44,153		33,868	1,608	3
4	7	MAINTENANCE BENEFITS	ACTUAL FEES	14	61,694		33,868	2,247	4
5	19	PROFESSIONAL FEES	ACTUAL FEES	14	1,467		33,868	53	5
6	20	LICENSES	ACTUAL FEES	14	1,402		33,868	51	6
7	21	OFFICE EXPENSE	ACTUAL FEES	14	5,306		33,868	193	7
8	25	AUTO / TRAVEL EXPENSE	ACTUAL FEES	14	36,073		33,868	1,314	8
9	26	INSURANCE	ACTUAL FEES	14	12,121		33,868	442	9
10	30	DEPRECIATION	ACTUAL FEES	14	13,517		33,868	492	10
11	35	AUTO LEASE	ACTUAL FEES	14	135		33,868	5	11
12	6	MAINTENANCE SUPPLIES	DIRECT ALLOCATION	13	6,541			166	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 620,549	\$ 435,123		\$ 22,532	25

Facility Name & ID Number Rosewood Care Center Of Rockford

# 0049270

Report Period Beginning:

07/01/15

Ending: 06/30/16

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	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
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Rosewood Care Center Of Rockford

# 0049270

Report Period Beginning:

07/01/15

Ending: 06/30/16

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	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
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Rosewood Care Center Of Rockford

# 0049270

Report Period Beginning:

07/01/15

Ending: 06/30/16

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	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
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Rosewood Care Center Of Rockford

# 0049270

Report Period Beginning:

07/01/15

Ending: 06/30/16

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	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
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

Rosewood Care Center Of Rockford

# 0049270

Report Period Beginning:

07/01/15

Ending:

06/30/16

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	Berkadia		X	Mortgage	73916.21	11/1/04	\$ 4,941,300	\$ 9,670,313	12/1/39	0.0470	\$ 454,073	1						
2												2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6	Bravo Holding		X	Note Payable				3,022,790			151,090	6						
7	MidCap		X	Line of Credit							75,030	7						
8												8						
9	<b>TOTAL Facility Related</b>				73916.21		\$ 4,941,300	\$ 12,693,104			\$ 680,193	9						
<b>B. Non-Facility Related*</b>																		
10	Bldg. Co. Interest Income		X								(35)	10						
11	Allocated from MAS	X									15,941	11						
12	Allocated from Bravo Holding C	X									(1,098)	12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 14,808	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 4,941,300	\$ 12,693,104			\$ 695,001	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ 48,649      Line # 36

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

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

Facility Name & ID Number

Rosewood Care Center Of Rockford

# 0049270

Report Period Beginning:

07/01/15

Ending:

06/30/16

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

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

1	2	3	4	5	6		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1						\$	\$			\$	1							
2											2							
3											3							
4											4							
5											5							
6											6							
7	<b>TOTAL Long-Term</b>										7							
<b>Working Capital</b>																		
8						\$	\$			\$	8							
9											9							
10											10							
11											11							
12											12							
13											13							
14	<b>TOTAL Working Capital</b>										14							
<b>B. Non-Facility Related*</b>																		
15						\$	\$			\$	15							
16											16							
17											17							
18											18							
19											19							
20	<b>TOTAL Non-Facility Related</b>										20							

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)







Facility Name & ID Number Rosewood Care Center Of Rockford

# 0049270 Report Period Beginning:

07/01/15 Ending:

06/30/16

**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: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs:

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>41,042</u>	<u>2013</u>	<u>\$ 262,474</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>41,042</b>		<b>\$ 262,474</b>	<b>3</b>

**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	\$ 165,985	40	\$ 67,250	\$ (98,735)	\$ 168,125	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
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

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Rosewood Care Center Of Rockford

# 0049270

Report Period Beginning:

07/01/15

Ending:

06/30/16

**XI. OWNERSHIP COSTS (continued)**

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

1	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								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		35,909			1,253	1,253	1,710	67
68								68
69			10,571			(10,571)		69
70		\$ 2,725,914	\$ 176,556		\$ 68,503	\$ (108,053)	\$ 169,835	70

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

Facility Name & ID Number Rosewood Care Center Of Rockford

# 0049270

Report Period Beginning:

07/01/15

Ending:

06/30/16

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 2,725,914	\$ 176,556		\$ 68,503	\$ (108,053)	\$ 169,835	1
2	Compressor Rotary Repair	2015	2,940		20	147	147	147	2
3	Capacitor Repair	2016	3,363		20	168	168	168	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,732,217	\$ 176,556		\$ 68,818	\$ (107,738)	\$ 170,150	34

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

Facility Name & ID Number **Rosewood Care Center Of Rockford**

# **0049270**

Report Period Beginning:

**07/01/15**

Ending:

**06/30/16**

**XI. OWNERSHIP COSTS (continued)**

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

1	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		\$ 2,732,217	\$ 176,556		\$ 68,818	\$ (107,738)	\$ 170,150	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 2,732,217	\$ 176,556		\$ 68,818	\$ (107,738)	\$ 170,150	34

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

Facility Name & ID Number **Rosewood Care Center Of Rockford**

# **0049270**

Report Period Beginning:

**07/01/15**

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**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	
1		\$ 2,732,217	\$ 176,556		\$ 68,818	\$ (107,738)	\$ 170,150	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 2,732,217	\$ 176,556		\$ 68,818	\$ (107,738)	\$ 170,150	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	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		\$ 2,732,217	\$ 176,556		\$ 68,818	\$ (107,738)	\$ 170,150	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 2,732,217	\$ 176,556		\$ 68,818	\$ (107,738)	\$ 170,150	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Building Company</b>		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9	<b>Doors</b>	2014	4,774		40	119	119	199	9
10	<b>Doors</b>	2015	8,790		40	220	220	305	10
11	<b>Repair Damaged Roof from Hail Storm</b>	2015	9,520		40	238	238	357	11
12	<b>Seal Coating</b>	2015	4,557		25	182	182	273	12
13	<b>Install (2) Fire Dampers in Mechanical Room</b>	2015	3,275		10	328	328	410	13
14	<b>Replace Backflow Preventor</b>	2016	4,993		10	166	166	166	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 35,909	\$		\$ 1,253	\$ 1,253	\$ 1,710	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	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		\$ 35,909	\$		\$ 1,253	\$ 1,253	\$ 1,710	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 35,909	\$		\$ 1,253	\$ 1,253	\$ 1,710	34

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

Facility Name & ID Number Rosewood Care Center Of Rockford

# 0049270

Report Period Beginning:

07/01/15

Ending:

06/30/16

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

**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
1		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	<b>TOTAL (lines 1 thru 33)</b>	\$	\$		\$	\$	\$

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

Facility Name & ID Number Rosewood Care Center Of Rockford

# 0049270

Report Period Beginning:

07/01/15

Ending:

06/30/16

**XI. OWNERSHIP COSTS (continued)**

**C. Equipment Costs-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 73,514	\$ 2,532	\$ 13,755	\$ 11,223	10	\$ 45,311	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	14,587	108	108		10	14,587	73
74								74
75	<b>TOTALS</b>	\$ 88,101	\$ 2,640	\$ 13,863	\$ 11,223		\$ 59,898	75

**D. Vehicle Costs. (See instructions.)\***

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from MAS	various	\$ 44,284	\$ 11,290	\$ 11,290		5	\$ 28,783	76
77		Allocated from Senior Living Ser	various	5,453	492	492		5	5,102	77
78										78
79										79
80	<b>TOTALS</b>			\$ 49,737	\$ 11,782	\$ 11,782			\$ 33,885	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)	\$ 3,132,529	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 190,978	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 94,463	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (96,515)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 263,933	85

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

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

**G. Construction-in-Progress**

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Off-Site Storage				3,882			5
6	Allocated from MAS				12,955			6
7	TOTAL				\$ 16,837			7

\*\*

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Bravo Nursing Home		\$	\$ 8	17
18	Allocated from Bravo Holding Company			5	18
19	Allocated from Senior Living Services			5	19
20					20
21	TOTAL		\$	\$ 18	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ /2017 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2018 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2019 \$ \_\_\_\_\_

\* 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.

**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? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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			
		1	2	3	4
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5	6	7	8		
			Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)						Total Cost (Col. 3 + 5 + 6)
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	39 - 03	hrs	\$				\$ 379,681	\$			\$ 379,681	1	
2	Licensed Speech and Language Development Therapist	39 - 03	hrs					35,088				35,088	2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist	39 - 03	hrs					371,231				371,231	4	
5	Physician Care		visits										5	
6	Dental Care		visits										6	
7	Work Related Program		hrs										7	
8	Habilitation		hrs										8	
9	Pharmacy	39 - 02	# of prescrpts						294,480			294,480	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10	
11	Academic Education		hrs										11	
12	Other (specify): _____												12	
13	Other (specify): <u>See Supplemental</u>							10,851	17,975			28,826	13	
14	<b>TOTAL</b>			\$				\$ 796,851	\$ 312,455			\$ 1,109,306	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.

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **06/30/16**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 997	\$ 5,375	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,856,405	1,856,405	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	43,729	47,205	6
7	Other Prepaid Expenses		184,162	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <b>See Attached Schedule</b>	7,888	124,951	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,909,019	\$ 2,218,098	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		985,300	13
14	Buildings, at Historical Cost		4,053,455	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	51,556	651,173	16
17	Accumulated Depreciation (book methods)	(32,115)	(3,057,682)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 19,441	\$ 2,632,246	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,928,460	\$ 4,850,344	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 2,310,193	\$ 2,341,844	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	3,022,790	3,022,790	29
30	Accrued Salaries Payable	134,004	134,004	30
31	Accrued Taxes Payable (excluding real estate taxes)	148,638	148,638	31
32	Accrued Real Estate Taxes(Sch.IX-B)		126,692	32
33	Accrued Interest Payable		508,142	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	3,529	3,529	35
	<b>Other Current Liabilities(specify):</b>			
36	<b>See Attached Schedule</b>	1,339,563	324,960	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 6,958,717	\$ 6,610,599	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,670,313	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 9,670,313	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 6,958,717	\$ 16,280,912	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (5,030,257)	\$ (11,430,568)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,928,460	\$ 4,850,344	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(3,596,260)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior Year Adjustment</b>	<b>(745)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(3,597,005)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(1,433,252)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(1,433,252)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(5,030,257)</b>	<b>24</b> *

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

Facility Name &amp; ID Number Rosewood Care Center Of Rockford

# 0049270

Report Period Beginning: 07/01/15

Ending:

06/30/16

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 6,864,213	1
2	Discounts and Allowances for all Levels	(2,452,313)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,411,900	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,245,448	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 2,245,448	8
<b>C. Other Operating Revenue</b>			
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	800	13
14	Non-Patient Meals	1,444	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	238,675	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	65,988	19
20	Radiology and X-Ray	8,524	20
21	Other Medical Services	97,098	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 412,529	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>See Supplemental Schedule</b>	10,888	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 10,888	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,080,765	30

2

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,284,252	31
32	Health Care	2,840,884	32
33	General Administration	1,779,137	33
<b>B. Capital Expense</b>			
34	Ownership	1,209,664	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,194,772	35
36	Provider Participation Fee	205,308	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 8,514,017	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(1,433,252)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (1,433,252)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,316,705	44
45	Private Pay - Net Inpatient Revenue	953,986	45
46	Medicare - Net Inpatient Revenue	928,549	46
47	Other-(specify) <u>Managed Care</u>	212,660	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 4,411,900	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.

Facility Name & ID Number Rosewood Care Center Of Rockford

# 0049270

Report Period Beginning: 07/01/15

Ending: 06/30/16

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	2,157	2,290	\$ 92,233	\$ 40.28	1
2	Assistant Director of Nursing	2,378	2,562	92,424	36.07	2
3	Registered Nurses	16,478	17,790	474,376	26.67	3
4	Licensed Practical Nurses	14,085	15,015	354,958	23.64	4
5	CNAs & Orderlies	59,786	62,466	753,771	12.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,918	3,078	55,064	17.89	8
9	Activity Director	2,147	2,326	27,439	11.80	9
10	Activity Assistants	3,451	3,563	29,291	8.22	10
11	Social Service Workers	4,373	4,509	67,764	15.03	11
12	Dietician					12
13	Food Service Supervisor	264	272	3,930	14.45	13
14	Head Cook					14
15	Cook Helpers/Assistants	2,033	2,640	24,839	9.41	15
16	Dishwashers					16
17	Maintenance Workers	2,375	2,606	40,266	15.45	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,080	2,128	97,276	45.71	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,987	9,716	119,980	12.35	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	4,576	4,776	66,849	14.00	31
32	Other Health Care(specify)					32
33	Other(specify)	3,691	4,060	83,526	20.57	33
34	TOTAL (lines 1 - 33)	131,779	139,797	\$ 2,383,986 *	\$ 17.05	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	\$ 1,340	01-03	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,908	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,200	11-03	44
45	Social Service Consultant	Monthly	2,200	12-03	45
46	Other(specify)				46
47	Outsourced Dietary	Monthly	348,300	01-03	47
48					48
49	TOTAL (lines 35 - 48)		\$ 361,948		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	5,537	\$ 227,033	10-03	50
51	Licensed Practical Nurses	6,137	208,649	10-03	51
52	Certified Nurse Assistants/Aides	4,941	103,766	10-03	52
53	TOTAL (lines 50 - 52)	16,615	\$ 539,448		53



Facility Name & ID Number Rosewood Care Center Of Rockford# 0049270Report Period Beginning: 07/01/15Ending: 06/30/16**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IHCA \$6,869
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 53,214 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. \$ 205,308  
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. \$ Yes Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,444
- (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? 100% Ln 14  
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