

Facility Name & ID Number Rosewood Care Center Of Alton

0049288 Report Period Beginning: 07/01/16 Ending: 06/30/17

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	180	Skilled (SNF)	180	65,700	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	180	TOTALS	180	65,700	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	13,974	18,646	8,147	40,767	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,974	18,646	8,147	40,767	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.05%

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

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

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

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

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 12/1/2007

J. Was the facility purchased or leased after January 1, 1978?
YES Date 12/1/2007 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 89 and days of care provided 5,552

Medicare Intermediary Novitas Solutions, Inc

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/2017 Fiscal Year: 6/30/2017

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

Facility Name & ID Number Rosewood Care Center Of Alton # 0049288 Report Period Beginning: 07/01/16 Ending: 06/30/17

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		373	700,912	701,285	701,285		701,285			1
2	Food Purchase		355,393		355,393	355,393	(3,065)	352,328			2
3	Housekeeping		19,948	257,870	277,818	277,818		277,818			3
4	Laundry			171,914	171,914	171,914		171,914			4
5	Heat and Other Utilities			189,003	189,003	189,003	(14,167)	174,836			5
6	Maintenance	72,330	10,284	366,056	448,670	448,670	(84,011)	364,659			6
7	Other (specify):*						6,734	6,734			7
8	TOTAL General Services	72,330	385,998	1,685,755	2,144,083	2,144,083	(94,509)	2,049,574			8
	B. Health Care and Programs										
9	Medical Director			26,000	26,000	26,000		26,000			9
10	Nursing and Medical Records	3,067,885	259,644	17,644	3,345,173	3,345,173	46,858	3,392,031			10
10a	Therapy	119,396	967		120,363	120,363		120,363			10a
11	Activities	80,252	4,570	2,600	87,422	87,422		87,422			11
12	Social Services	85,568		2,600	88,168	88,168		88,168			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*						3,253	3,253			15
16	TOTAL Health Care and Programs	3,353,101	265,181	48,844	3,667,126	3,667,126	50,111	3,717,237			16
	C. General Administration										
17	Administrative	77,645		424,197	501,842	501,842	(383,228)	118,614			17
18	Directors Fees										18
19	Professional Services			123,025	123,025	123,025	(10,622)	112,403			19
20	Dues, Fees, Subscriptions & Promotions			18,323	18,323	18,323	327	18,650			20
21	Clerical & General Office Expenses	148,975	26,043	370,993	546,011	546,011	(117,700)	428,311			21
22	Employee Benefits & Payroll Taxes			539,935	539,935	539,935		539,935			22
23	Inservice Training & Education										23
24	Travel and Seminar			2,731	2,731	2,731	1,458	4,189			24
25	Other Admin. Staff Transportation			9,288	9,288	9,288	11,631	20,919			25
26	Insurance-Prop.Liab.Malpractice			121,200	121,200	121,200	19,498	140,698			26
27	Other (specify):*						30,731	30,731			27
28	TOTAL General Administration	226,620	26,043	1,609,692	1,862,355	1,862,355	(447,905)	1,414,450			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,652,051	677,222	3,344,291	7,673,564	7,673,564	(492,303)	7,181,261			29

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

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

Facility Name & ID Number

Rosewood Care Center Of Alton

#0049288

Report Period Beginning:

07/01/16

Ending:

06/30/17

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			18,549	18,549		18,549	203,396	221,945			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			115,657	115,657		115,657	445,023	560,680			32
33	Real Estate Taxes							254,150	254,150			33
34	Rent-Facility & Grounds			1,287,606	1,287,606		1,287,606	(1,260,168)	27,438			34
35	Rent-Equipment & Vehicles			11,488	11,488		11,488		11,488			35
36	Other (specify):*			23,665	23,665		23,665	49,120	72,785			36
37	TOTAL Ownership			1,456,965	1,456,965		1,456,965	(308,480)	1,148,485			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		368,750	908,648	1,277,398		1,277,398		1,277,398			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			309,291	309,291		309,291		309,291			42
43	Other (specify):*	85,785		8,213	93,998		93,998	(93,998)	0			43
44	TOTAL Special Cost Centers	85,785	368,750	1,226,152	1,680,687		1,680,687	(93,998)	1,586,689			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,737,836	1,045,972	6,027,408	10,811,216		10,811,216	(894,781)	9,916,435			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	
	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	(1,019)	02		4
5	Telephone, TV & Radio in Resident Rooms	(14,757)	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	(38,027)	30		9
10	Interest and Other Investment Income	(80,650)	32		10
11	Discounts, Allowances, Rebates & Refunds	(11,597)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,625)	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	(5,123)	21		18
19	Entertainment	(594)	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	(264,844)	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	(256)	20		28
29	Other-Attach Schedule	(242,401)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (660,893)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(233,888)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (233,888)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (894,781)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	52

Rosewood Care Center Of Alton

ID# 0049288

Report Period Beginning: 07/01/16

Ending: 06/30/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Marketing Salary	\$ (80,485)	43	1
2	Marketing Expense	(8,213)	43	2
3	Bank Charges	(2,707)	21	3
4	Vending Income	(421)	02	4
5	Line of Credit Fees	(23,665)	36	5
6	Marketing Bonus	(5,300)	43	6
7	Vendor Late Charges	(42,748)	21	7
8	Non-Allowable Legal	(1,065)	19	8
9	Capitalized R&M	(38,593)	06	9
10	PAC Dues	(3,353)	20	10
11	Building Co. - Audit Fees	(9,720)	19	11
12	Building Co. - Professional Fees	(40)	19	12
13	Building Co. - Bank Fees	(16,403)	21	13
14	Building Co. - Amortization Loan Fee	(7,356)	36	14
15	Marketing Travel	(2,333)	25	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(242,401)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Center Of Alton# 0049288

Report Period Beginning:

07/01/16

Ending:

06/30/17

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													1
2	Food Purchase	(3,065)											(3,065)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(14,757)					307	283					(14,167)	5
6	Maintenance	(38,593)					133	(45,551)					(84,011)	6
7	Other (specify):*							6,734					6,734	7
8	TOTAL General Services	(56,415)					439	(38,534)					(94,509)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				46,858								46,858	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				3,253								3,253	15
16	TOTAL Health Care and Programs				50,111								50,111	16
	C. General Administration													
17	Administrative				(97,031)		(286,197)						(383,228)	17
18	Directors Fees													18
19	Professional Services	(10,825)	9,760	19,281	467	(29,304)							(10,622)	19
20	Fees, Subscriptions & Promotions	(3,609)			5	58	3,735	138					327	20
21	Clerical & General Office Expenses	(344,015)	23,603		1,095	9,034	191,667	916					(117,700)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			995	154	125	184						1,458	24
25	Other Admin. Staff Transportation	(2,333)			3,827	864	4,559	4,713					11,631	25
26	Insurance-Prop.Liab.Malpractice		12,750				5,503	1,245					19,498	26
27	Other (specify):*				4,429	1,051	25,251						30,731	27
28	TOTAL General Administration	(360,782)	46,113	20,276	(87,054)	(18,172)	(55,298)	7,013					(447,905)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(417,197)	46,113	20,276	(36,943)	(18,172)	(54,859)	(31,521)					(492,303)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Center Of Alton # 0049288 Report Period Beginning: 07/01/16 Ending: 06/30/17

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	(38,027)	225,633				14,978	812					203,396	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(80,650)	543,014	(44,486)			27,145						445,023	32
33	Real Estate Taxes		254,150										254,150	33
34	Rent-Facility & Grounds		(1,281,060)				20,892						(1,260,168)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*	(31,021)	80,141										49,120	36
37	TOTAL Ownership	(149,698)	(178,122)	(44,486)			63,014	812					(308,480)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(93,998)											(93,998)	43
44	TOTAL Special Cost Centers	(93,998)											(93,998)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(660,893)	(132,009)	(24,210)	(36,943)	(18,172)	8,156	(30,709)					(894,781)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6 - Supplemental		See Page 6 - Supplemental		See Page 6 - Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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	\$ 1,281,060	Alton Real Estate, Inc.		\$	\$ (1,281,060)	1
2	V	32 Interest Income - Escrow	36	Alton Real Estate, Inc.			(36)	2
3	V	19 Audit Fees		Alton Real Estate, Inc.		9,720	9,720	3
4	V	19 Professional Fees		Alton Real Estate, Inc.		40	40	4
5	V	21 Bank Charges		Alton Real Estate, Inc.		16,403	16,403	5
6	V	32 Interest Expense - HUD Mortgage		Alton Real Estate, Inc.		543,050	543,050	6
7	V	36 Int Expense - HUD MIP		Alton Real Estate, Inc.		72,785	72,785	7
8	V	33 Real Estate Tax		Alton Real Estate, Inc.		254,150	254,150	8
9	V	30 Depreciation		Alton Real Estate, Inc.		225,633	225,633	9
10	V	36 Amortization Loan Fee		Alton Real Estate, Inc.		7,356	7,356	10
11	V	21 Base Admin Fee (Page 6D)		Alton Real Estate, Inc.		7,200	7,200	11
12	V	26 Insurance Expense - Property		Alton Real Estate, Inc.		12,750	12,750	12
13	V							13
14	Total		\$ 1,281,096			\$ 1,149,087	\$ * (132,009)	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	19 PROFESSIONAL FEES	\$	BRAVO HOLDING COMPANY	100.00%	\$ 19,281	\$	19,281	15
16	V	24 SEMINAR EXPENSE		BRAVO HOLDING COMPANY	100.00%	995		995	16
17	V	32 INTEREST		BRAVO HOLDING COMPANY	100.00%	(44,486)		(44,486)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ (24,210)	\$ *	(24,210)	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	10 CORPORATE RN SALARIES	\$	BRAVO NURSING HOME SERVICES, INC.	100.00%	\$ 46,858	\$	46,858	15
16	V	15 CORPORATE RN SALARIES BENEFITS		BRAVO NURSING HOME SERVICES, INC.	100.00%	3,253		3,253	16
17	V	17 ADMINISTRATIVE SALARIES		BRAVO NURSING HOME SERVICES, INC.	100.00%	40,969		40,969	17
18	V	19 PROFESSIONAL FEES		BRAVO NURSING HOME SERVICES, INC.	100.00%	467		467	18
19	V	20 DUES & SUBSCRIPTIONS		BRAVO NURSING HOME SERVICES, INC.	100.00%	5		5	19
20	V	21 OFFICE EXPENSES		BRAVO NURSING HOME SERVICES, INC.	100.00%	1,095		1,095	20
21	V	24 SEMINAR & LODGING EXPENSE		BRAVO NURSING HOME SERVICES, INC.	100.00%	154		154	21
22	V	25 AUTO EXPENSE		BRAVO NURSING HOME SERVICES, INC.	100.00%	3,827		3,827	22
23	V	27 ADMINISTRATIVE & OFFICE BENEFITS		BRAVO NURSING HOME SERVICES, INC.	100.00%	4,429		4,429	23
24	V								24
25	V								25
26	V	17 ADMINISTRATIVE FEE	138,000	BRAVO NURSING HOME SERVICES, INC.	100.00%			(138,000)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 138,000			\$ 101,057	\$ *	(36,943)	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%	\$ 793	\$	793	15
16	V	20 LICENSES		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	58		58	16
17	V	21 LEGAL SALARIES		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	8,914		8,914	17
18	V	21 OFFICE EXPENSE		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	120		120	18
19	V	24 SEMINAR		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	125		125	19
20	V	25 AUTO / TRAVEL EXPENSE		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	864		864	20
21	V	27 EMPLOYEE BENEFITS		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	1,051		1,051	21
22	V								22
23	V	19 PROFESSIONAL FEES	30,057	CLAIMS ADMINISTRATION SERVICES, LLC	100.00%			(30,057)	23
24	V	19 PROFESSIONAL FEES (BLDG CO)	40	CLAIMS ADMINISTRATION SERVICES, LLC	100.00%			(40)	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		\$ 30,097			\$ 11,925	\$ *	(18,172)	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	\$	MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	\$ 307	\$	307	15
16	V	6 MAINTENANCE EXPENSE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	133		133	16
17	V	20 DUES, SUBSCRIPTIONS, LICENSES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	3,735		3,735	17
18	V	21 OFFICE SALARIES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	150,385		150,385	18
19	V	21 OFFICE EXPENSES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	48,482		48,482	19
20	V	24 SEMINAR		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	184		184	20
21	V	25 TRAVEL EXPENSE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	4,559		4,559	21
22	V	26 INSURANCE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	5,503		5,503	22
23	V	27 EMPLOYEE BENEFITS		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	25,251		25,251	23
24	V	30 DEPRECIATION		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	14,978		14,978	24
25	V	32 INTEREST		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	27,145		27,145	25
26	V	34 BUILDING RENT		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	20,892		20,892	26
27	V								27
28	V								28
29	V	17 ADMINISTRATIVE FEE	286,197	MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%			(286,197)	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		\$ 293,397			\$ 301,553	\$ *	8,156	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%	\$ 283	\$	283	15
16	V	6 MAINTENANCE SALARY		SENIOR LIVING SERVICES, INC.	100.00%	44,835		44,835	16
17	V	6 MAINTENANCE EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	4,018		4,018	17
18	V	7 MAINTENANCE BENEFITS		SENIOR LIVING SERVICES, INC.	100.00%	6,734		6,734	18
19	V	20 LICENSES		SENIOR LIVING SERVICES, INC.	100.00%	138		138	19
20	V	21 OFFICE EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	916		916	20
21	V	25 AUTO / TRAVEL EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	4,713		4,713	21
22	V	26 INSURANCE		SENIOR LIVING SERVICES, INC.	100.00%	1,245		1,245	22
23	V	30 DEPRECIATION		SENIOR LIVING SERVICES, INC.	100.00%	812		812	23
24	V								24
25	V	6 MAINTENANCE SERVICES	94,581	SENIOR LIVING SERVICES, INC.	100.00%	177		(94,404)	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		\$ 94,581			\$ 63,872	\$ *	(30,709)	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	Total		\$			\$	\$ *	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	Total		\$			\$	\$ *	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	Total		\$			\$	\$ *	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	Total		\$			\$	\$ *	39

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

Facility Name & ID Number Rosewood Care Center Of Alton # 0049288 Report Period Beginning: 07/01/16 Ending: 06/30/17

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

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

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

Facility Name & ID Number Rosewood Care Center Of Alton

0049288

Report Period Beginning:

07/01/16

Ending: 06/30/17

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	TOTALS				\$	\$		\$	25

Facility Name & ID Number Rosewood Care Center Of Alton

0049288

Report Period Beginning:

07/01/16

Ending: 06/30/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	PATIENT DAYS	445,412	14	\$ 210,656	\$ 40,767	\$ 19,281	1
2	24	SEMINAR EXPENSE	PATIENT DAYS	445,412	14	10,876	40,767	995	2
3	32	INTEREST	PATIENT DAYS	445,412	14	(486,047)	40,767	(44,486)	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ (264,515)	\$	\$ (24,210)	25

Facility Name & ID Number Rosewood Care Center Of Alton

0049288

Report Period Beginning:

07/01/16

Ending: 06/30/17

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	10	CORPORATE RN SALARIES	PAT. DAYS	445,412	14	\$ 511,965	\$ 40,767	\$ 46,858	1
2	15	CORPORATE RN SALARIES BI	PAT. DAYS	445,412	14	35,539	40,767	3,253	2
3	17	ADMINISTRATIVE SALARIES	PAT. DAYS	445,412	14	447,622	40,767	40,969	3
4	19	PROFESSIONAL FEES	PAT. DAYS	445,412	14	5,100	40,767	467	4
5	20	DUES & SUBSCRIPTIONS	PAT. DAYS	445,412	14	53	40,767	5	5
6	21	OFFICE EXPENSES	PAT. DAYS	445,412	14	11,963	40,767	1,095	6
7	24	SEMINAR & LODGING EXPEN	PAT. DAYS	445,412	14	1,683	40,767	154	7
8	25	AUTO EXPENSE	PAT. DAYS	445,412	14	41,816	40,767	3,827	8
9	27	ADMINISTRATIVE & OFFICE I	PAT. DAYS	445,412	14	48,387	40,767	4,429	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					\$ 1,104,130	\$ 959,587	\$ 101,057	25

Facility Name & ID Number Rosewood Care Center Of Alton

0049288

Report Period Beginning:

07/01/16

Ending: 06/30/17

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	439,804	14	\$ 15,685	\$ 22,224	\$ 793	1
2	20	LICENSES	ACTUAL FEES	439,804	14	1,155	22,224	58	2
3	21	LEGAL SALARIES	ACTUAL FEES	439,804	14	176,396	176,396	8,914	3
4	21	OFFICE EXPENSE	ACTUAL FEES	439,804	14	2,382	22,224	120	4
5	24	SEMINAR	ACTUAL FEES	439,804	14	2,470	22,224	125	5
6	25	AUTO / TRAVEL EXPENSE	ACTUAL FEES	439,804	14	17,094	22,224	864	6
7	27	EMPLOYEE BENEFITS	ACTUAL FEES	439,804	14	20,803	22,224	1,051	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					\$ 235,985	\$ 176,396	\$ 11,925	25

Facility Name & ID Number Rosewood Care Center Of Alton

0049288

Report Period Beginning:

07/01/16

Ending: 06/30/17

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	445,412	14	\$ 3,350	\$ 40,767	\$ 307	1
2	6	MAINTENANCE EXPENSE	PAT. DAYS	445,412	14	1,452	40,767	133	2
3	20	DUES, SUBSCRIPTIONS, LICEN	PAT. DAYS	445,412	14	40,807	40,767	3,735	3
4	21	OFFICE SALARIES	PAT. DAYS	445,412	14	1,643,080	1,643,080	150,385	4
5	21	OFFICE EXPENSES	PAT. DAYS	445,412	14	529,702	40,767	48,482	5
6	24	SEMINAR	PAT. DAYS	445,412	14	2,006	40,767	184	6
7	25	TRAVEL EXPENSE	PAT. DAYS	445,412	14	49,808	40,767	4,559	7
8	26	INSURANCE	PAT. DAYS	445,412	14	60,126	40,767	5,503	8
9	27	EMPLOYEE BENEFITS	PAT. DAYS	445,412	14	275,890	40,767	25,251	9
10	30	DEPRECIATION	PAT. DAYS	445,412	14	163,642	40,767	14,978	10
11	32	INTEREST	PAT. DAYS	445,412	14	296,581	40,767	27,145	11
12	34	BUILDING RENT	PAT. DAYS	445,412	14	228,258	40,767	20,892	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					\$ 3,294,702	\$ 1,643,080	\$ 301,553	25

Facility Name & ID Number Rosewood Care Center Of Alton

0049288

Report Period Beginning:

07/01/16

Ending: 06/30/17

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	\$ 2,789	\$	94,581	\$ 283	1
2	6	MAINTENANCE SALARY	ACTUAL FEES	14	441,618	441,618	94,581	44,835	2
3	6	MAINTENANCE EXPENSE	ACTUAL FEES	14	39,580		94,581	4,018	3
4	7	MAINTENANCE BENEFITS	ACTUAL FEES	14	66,326		94,581	6,734	4
5	20	LICENSES	ACTUAL FEES	14	1,361		94,581	138	5
6	21	OFFICE EXPENSE	ACTUAL FEES	14	9,024		94,581	916	6
7	25	AUTO / TRAVEL EXPENSE	ACTUAL FEES	14	46,424		94,581	4,713	7
8	26	INSURANCE	ACTUAL FEES	14	12,265		94,581	1,245	8
9	30	DEPRECIATION	ACTUAL FEES	14	8,001		94,581	812	9
10									10
11	6	MAINTENANCE SERVICES	DIRECT ALLOCATION	14	4,421			177	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				\$ 631,809	\$ 441,618		\$ 63,872	25

Facility Name & ID Number Rosewood Care Center Of Alton

0049288

Report Period Beginning:

07/01/16

Ending: 06/30/17

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	TOTALS				\$	\$		\$	25

Facility Name & ID Number Rosewood Care Center Of Alton

0049288

Report Period Beginning:

07/01/16

Ending: 06/30/17

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	TOTALS				\$	\$		\$	25

Facility Name & ID Number Rosewood Care Center Of Alton

0049288

Report Period Beginning:

07/01/16

Ending: 06/30/17

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	TOTALS				\$	\$		\$	25

Facility Name & ID Number Rosewood Care Center Of Alton

0049288

Report Period Beginning:

07/01/16

Ending: 06/30/17

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	TOTALS				\$	\$		\$	25

Facility Name & ID Number

Rosewood Care Center Of Alton

0049288

Report Period Beginning:

07/01/16

Ending:

06/30/17

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		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	\$92,147.48	6/1/02	\$ 16,150,000	\$ 14,749,760	6/2035	0.0369	\$ 543,050	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	MidCap		X	Revolving Line of Credit		8/1/09			12/31/2015	5.0000	115,657	6								
7												7								
8												8								
9	TOTAL Facility Related				\$92,147.48		\$ 16,150,000	\$ 14,749,760			\$ 658,707	9								
B. Non-Facility Related*																				
10	Interest Income		X								(8)	10								
11	Alloc. From Midwest Admin. Serv		X								27,145	11								
12	Allocated from Bravo Holding		X								(44,486)	12								
13	See Supplemental Schedule										(80,678)	13								
14	TOTAL Non-Facility Related						\$	\$			\$ (98,027)	14								
15	TOTALS (line 9+line14)						\$ 16,150,000	\$ 14,749,760			\$ 560,680	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 72,785 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 Alton

0049288 Report Period Beginning:

07/01/16 Ending:

06/30/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 58,176 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

1. Total Amount Incurred: _____ 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>58,679</u>	<u>1988</u>	<u>\$ 277,647</u>	<u>1</u>
2	<u>60 bed Addition</u>	<u>19,479</u>	<u>1998</u>		<u>2</u>
3	TOTALS	78,158		\$ 277,647	3

Facility Name & ID Number Rosewood Care Center Of Alton

0049288

Report Period Beginning:

07/01/16

Ending:

06/30/17

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		1989	1989	\$ 3,401,372	\$ 225,633	40	\$ 88,165	\$ (137,468)	\$ 2,597,362	4
5	60		1997	1997	2,186,719		40	70,292	70,292	1,370,599	5
6											6
7											7
8											8
	Improvement Type**										
9	Various		2012		4,070		20	407	407	2,035	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

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		597,339			26,312	26,312	229,912	67
68		398	80		80		80	68
69			18,549			(18,549)		69
70		\$ 6,189,898	\$ 244,262		\$ 185,256	\$ (59,006)	\$ 4,199,988	70

**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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,189,898	\$ 244,262		\$ 185,256	\$ (59,006)	\$ 4,199,988	1
2	Wallpaper - Accent Walls In Resident Rooms	2014	18,900		20	2,700	2,700	9,450	2
3	Install Cables And Wires For Rooms 531,701,504 And Office	2016	4,746		20	237	237	237	3
4	Installed Repair Clamp In 300 Hall	2016	5,121		20	256	256	256	4
5	Repairs On Fire Sprinkler Systems	2017	8,839		20	442	442	442	5
6	Repaired Fire Sprinkler System	2017	3,297		20	165	165	165	6
7	Remove And Relocate Life Safety Circuits	2017	3,298		20	165	165	165	7
8	Install Fire/Life Safety Door Closers-Rooms 110,112,304,410&417	2017	4,714		20	236	236	236	8
9	Drywall Repairs - For Hallways 100-700, 900	2017	4,320		20	216	216	216	9
10	Repair Damaged Walls In Rooms 603,209,309,606 & 908	2017	4,259		20	213	213	213	10
11	Construction To Relocate Existing Beauty Shop & Therapy	2017							11
12	To Allow For Construction Of Resident Rooms 702 & 704	2017	18,135		20	907	907	907	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)		\$ 6,265,526	\$ 244,262		\$ 190,793	\$ (53,469)	\$ 4,212,275	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		\$ 6,265,526	\$ 244,262		\$ 190,793	\$ (53,469)	\$ 4,212,275	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		\$ 6,265,526	\$ 244,262		\$ 190,793	\$ (53,469)	\$ 4,212,275	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		\$ 6,265,526	\$ 244,262		\$ 190,793	\$ (53,469)	\$ 4,212,275	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)	\$ 6,265,526	\$ 244,262		\$ 190,793	\$ (53,469)	\$ 4,212,275	34

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

Facility Name & ID Number Rosewood Care Center Of Alton

0049288

Report Period Beginning:

07/01/16

Ending:

06/30/17

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		\$ 6,265,526	\$ 244,262		\$ 190,793	\$ (53,469)	\$ 4,212,275	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)	\$ 6,265,526	\$ 244,262		\$ 190,793	\$ (53,469)	\$ 4,212,275	34

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

Facility Name & ID Number Rosewood Care Center Of Alton

0049288

Report Period Beginning:

07/01/16

Ending:

06/30/17

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Walk-in Cooler	1989	5,438		10			5,438	9
10	Sinks	1989	3,528		10			3,528	10
11	Exhaust Hood	1989	4,609		10			4,609	11
12	Sign	1989	5,178		10			5,178	12
13	Generator	1989	14,857		10			14,857	13
14	Fence	1990	3,627		25			3,627	14
15	Service Door	1991	3,150		10			3,150	15
16	Lawn Sprinkler	1992	14,401		25	576	576	14,257	16
17	General Site Work	1992	27,500		25	1,100	1,100	27,225	17
18	Shingle Roof Replacement	2004	85,902		40	2,148	2,148	27,383	18
19	Parking Lot Improvements	2006	5,865		25	235	235	2,680	19
20	Heat Pumps	2006	13,231		10			13,231	20
21	Sidewalks	2008	1,498		25	60	60	529	21
22	Parking Lot Improvements	2009	5,385		25	215	215	1,812	22
23	Shower Tile	2009	5,779		10	578	578	4,527	23
24	McQuay Heat Pumps	2009	37,963		10	3,796	3,796	29,104	24
25	Boiler	2009	4,109		10	411	411	3,253	25
26	Sidewalk	2010	2,725		25	109	109	799	26
27	Overlay Parking Lot	2010	53,680		25	2,147	2,147	14,493	27
28	Sprinkler System	2010	7,996		10	800	800	5,265	28
29	Flooring - Dining Room	2010	8,255		40	206	206	1,426	29
30	Painting & Wallcovering - Dining Room	2010	11,552		40	289	289	1,998	30
31	Sprinkler System	2012	21,945		40	549	549	2,653	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 348,173	\$		\$ 13,219	\$ 13,219	\$ 191,022	34

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

Facility Name & ID Number Rosewood Care Center Of Alton# 0049288

Report Period Beginning:

07/01/16

Ending:

06/30/17**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 348,173	\$		\$ 13,219	\$	\$ 191,022	1
2	Replaced Backflows	2013	7,507		40	188	188	814	2
3	Sprinkler System	2013	21,885		40	547	547	2,296	3
4	Interior & Exterior Doors	2013	4,961		40	124	124	517	4
5	Water Heater	2013	3,583		40	90	90	375	5
6	Water Treatment	2013	3,089		40	77	77	321	6
7	Cooling Tower	2013	3,658		10	366	366	1,555	7
8	Window Panes & Screens	2013	3,596		40	90	90	367	8
9	Interior & Exterior Doors	2013	4,960		40	124	124	476	9
10	Sprinkler Work	2014	7,382		40	185	185	535	10
11	Firestopping	2014	4,455		40	111	111	278	11
12	Doors	2014	3,933		10	393	393	896	12
13	HVAC Work	2014	45,798		10	4,580	4,580	13,740	13
14	Hot Water Heater	2014	6,047		10	605	605	1,526	14
15	Hot Water Tank	2014	13,925		10	1,393	1,393	3,482	15
16	New Boilers (2)	2014	51,208		40	1,280	1,280	3,560	16
17	Boiler / Plumbing Repair	2014	11,128		40	278	278	741	17
18	Seal Coating	2014	5,495		25	220	220	623	18
19	Replace Concrete Sidewalk at 700 Wing Entrance	2014	2,995		25	120	120	330	19
20	Cooling Tower	2014	30,600		22	1,391	1,391	4,143	20
21	Replaced Water Source Heat Pump - Social Service Office	2014	2,860		10	286	286	858	21
22	Replaced Water Boiler - Main Building	2014	2,829		10	283	283	731	22
23	Fuel Tank	2016	7,272		10	364	364	728	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)		\$ 597,339	\$		\$ 26,312	\$ 13,093	\$ 229,912	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	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10	Allocated from Senior Living Services	2017	398	80	20	80		80	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)		\$ 398	\$ 80		\$ 80	\$	\$ 80	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		\$ 398	\$ 80		\$ 80		\$ 80	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)	\$ 398	\$ 80		\$ 80		\$ 80	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 94,530	\$ 3,370	\$ 18,812	\$ 15,442	10	\$ 74,528	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	22,695	120	120		10	22,695	73
74								74
75	TOTALS	\$ 117,225	\$ 3,490	\$ 18,932	\$ 15,442		\$ 97,223	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 Senior living Serv	2017	\$ 15,196	\$ 733	\$ 733		5	\$ 14,952	76
77		Allocated from Midwest Adminis	2017	61,419	11,488	11,488		5	50,557	77
78										78
79										79
80	TOTALS			\$ 76,615	\$ 12,221	\$ 12,221			\$ 65,509	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)	\$ 6,737,013	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 259,973	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 221,946	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (38,027)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,375,007	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Rosewood Care Center Of Alton

0049288

Report Period Beginning: 07/01/16

Ending: 06/30/17

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	Of-Site Storage			6,546			5
6	Alloc. From Midwest Admin. Services			20,892			6
7	TOTAL			\$ 27,438			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.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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: \$ 8,763 Description: See Attached Schedule

(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	Facility		\$	2,725	17
18					18
19					19
20					20
21	TOTAL		\$	2,725	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.

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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs				\$ 352,822				\$ 352,822	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				84,494				84,494	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				417,326				417,326	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					340,578			340,578	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify):						54,006	28,172			82,178	13
14	TOTAL				\$		\$ 908,648	\$ 368,750			\$ 1,277,398	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 **06/30/17**

(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	\$ 995	\$ 3,295	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,220,814	2,221,414	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	71,267	76,026	6
7	Other Prepaid Expenses	4,447	215,927	7
8	Accounts Receivable (owners or related parties)	2,487,937	2,487,937	8
9	Other(specify): See Attached Schedule	2,700	2,700	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,788,160	\$ 5,007,299	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		277,647	13
14	Buildings, at Historical Cost		568,081	14
15	Leasehold Improvements, at Historical Cost	22,970	6,087,182	15
16	Equipment, at Historical Cost	77,209	926,358	16
17	Accumulated Depreciation (book methods)	(75,201)	(4,751,003)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 24,978	\$ 3,108,265	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,813,138	\$ 8,115,564	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 3,843,851	\$ 3,952,150	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	208,173	208,173	30
31	Accrued Taxes Payable (excluding real estate taxes)	243,357	243,357	31
32	Accrued Real Estate Taxes(Sch.IX-B)		313,719	32
33	Accrued Interest Payable		1,137,570	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	14,853	40,913	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	3,423,784	1,008,016	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,734,018	\$ 6,903,898	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		14,749,760	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 14,749,760	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,734,018	\$ 21,653,658	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,920,880)	\$ (13,538,094)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,813,138	\$ 8,115,564	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,792,909)	1
2	Restatements (describe):		2
3	Post Closing Entries	(22,281)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,815,190)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,105,690)	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)	\$ (1,105,690)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (2,920,880)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Rosewood Care Center Of Alton

0049288

Report Period Beginning: 07/01/16

Ending:

06/30/17

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	\$ 9,363,167	1
2	Discounts and Allowances for all Levels	(2,642,767)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,720,400	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,427,286	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,427,286	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		13
14	Non-Patient Meals	1,019	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	359,354	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,617	19
20	Radiology and X-Ray	9,360	20
21	Other Medical Services	80,822	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 465,172	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	80,650	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 80,650	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	12,018	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 12,018	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,705,526	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	2,144,083	31
32	Health Care	3,667,126	32
33	General Administration	1,862,355	33
B. Capital Expense			
34	Ownership	1,456,965	34
C. Ancillary Expense			
35	Special Cost Centers	1,371,396	35
36	Provider Participation Fee	309,291	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,811,216	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,105,690)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,105,690)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,729,697	44
45	Private Pay - Net Inpatient Revenue	3,918,598	45
46	Medicare - Net Inpatient Revenue	889,125	46
47	Other-(specify) Insurance /Managed Care	182,980	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,720,400	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 Alton

0049288

Report Period Beginning:

07/01/16

Ending:

06/30/17

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	2,215	2,502	\$ 87,728	\$ 35.06	1
2	Assistant Director of Nursing	2,160	2,389	77,996	32.65	2
3	Registered Nurses	31,698	33,983	898,272	26.43	3
4	Licensed Practical Nurses	34,754	37,410	676,430	18.08	4
5	CNAs & Orderlies	128,184	136,449	1,271,177	9.32	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,424	6,860	119,396	17.40	8
9	Activity Director	2,225	2,225	28,566	12.84	9
10	Activity Assistants	4,102	4,457	51,686	11.60	10
11	Social Service Workers	4,275	4,826	85,568	17.73	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,850	4,195	72,330	17.24	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,128	2,264	77,645	34.30	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,062	8,558	148,975	17.41	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	3,785	4,390	56,282	12.82	31
32	Other Health Care(specify)					32
33	Other(specify)	4,134	4,515	85,785	19.00	33
34	TOTAL (lines 1 - 33)	237,996	255,023	\$ 3,737,836 *	\$ 14.66	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			35	
36	Medical Director	Monthly	26,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,431	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	2,600	11-03	44
45	Social Service Consultant	Monthly	2,600	12-03	45
46	Other(specify)				46
47	Dietary Consultant	Monthly	700,912	01 - 03	47
48					48
49	TOTAL (lines 35 - 48)		\$ 742,543		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	55	\$ 2,704	10-03	50
51	Licensed Practical Nurses	35	1,396	10-03	51
52	Certified Nurse Assistants/Aides	156	3,113	10-03	52
53	TOTAL (lines 50 - 52)	246	\$ 7,213		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Kimberley Cornel</u>	<u>Administrator</u>	<u>0</u>	\$ <u>77,645</u>	<u>Workers' Compensation Insurance</u>	\$ <u>111,520</u>	<u>IDPH License Fee</u>	\$ <u>1,990</u>	
				<u>Unemployment Compensation Insurance</u>	<u>50,946</u>	<u>Advertising: Employee Recruitment</u>	<u>1,072</u>	
				<u>FICA Taxes</u>	<u>266,641</u>	<u>Health Care Worker Background Check</u>	<u>5,436</u>	
				<u>Employee Health Insurance</u>	<u>95,238</u>	(Indicate # of checks performed <u>402.7</u>)		
				<u>Employee Meals</u>		<u>Patient Background Checks</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Dues & Subscriptions</u>	<u>6,216</u>	
				<u>Dental Insurance</u>	<u>6,037</u>	<u>Licenses</u>		
				<u>Employee Relations</u>	<u>1,345</u>	<u>Alloc. from Midwest Admin. Services</u>	<u>3,735</u>	
				<u>401K Expense</u>	<u>4,959</u>	<u>Alloc. from Bravo Nursing Home Services</u>	<u>5</u>	
				<u>Employee Physicals & Vaccinations</u>	<u>2,913</u>	<u>See Supplemental Schedule</u>	<u>196</u>	
				<u>Employee Drug Tests</u>	<u>337</u>	<u>Less: Public Relations Expense</u>	()	
						<u>Non-allowable advertising</u>	()	
						<u>Yellow page advertising</u>	()	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 77,645	TOTAL (agree to Schedule V, line 22, col.8)		\$ 18,650		
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>Bravo Nursing Home Services - Management Fee</u>			\$ <u>138,000</u>				<u>Out-of-State Travel</u>	\$
<u>Midwest Admin Services - Base Admin Fee</u>			<u>36,000</u>					
<u>Midwest Admin Services -Volume Admin Fee</u>			<u>250,197</u>				<u>In-State Travel</u>	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 424,197				<u>Seminar Expense</u>	<u>2,731</u>
(Attach a copy of any management service agreement)							<u>Alloc from Bravo Holidng Company</u>	<u>995</u>
C. Professional Services				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
Vendor/Payee	Type			Amount			\$ 4,189	
<u>Marcum LLP</u>	<u>Accounting</u>			\$ <u>9,735</u>				
<u>Quality HC</u>	<u>Billing & Tracking</u>			<u>45,108</u>				
<u>Resolute Healthcare Solutions</u>	<u>Claims Management</u>			<u>1,297</u>				
<u>Claims Administrative Services</u>	<u>Claims Management</u>			<u>30,057</u>				
<u>Infinite Solutions Support Charges</u>	<u>IT Support</u>			<u>32,353</u>				
<u>See Attached</u>	<u>Legal</u>			<u>4,475</u>				
TOTAL (agree to Schedule V, line 19, column 3)			\$ 123,025	TOTAL		\$		
(For legal fee disclosure, see page 39 of instructions)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Rosewood Care Center Of Alton# 0049288Report Period Beginning: 07/01/16Ending: 06/30/17**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA - \$8,489
- (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 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 91,680 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. \$ 309,291
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. \$ 1,019
- (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