

Facility Name & ID Number Rosewood Care Center Of Elgin

0049346 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	139	Skilled (SNF)	139	50,735	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	139	TOTALS	139	50,735	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	15,631	15,182	9,299	40,112	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,631	15,182	9,299	40,112	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.06%

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 12/01/2007

J. Was the facility purchased or leased after January 1, 1978?
YES Date 12/01/2007 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 67 and days of care provided 7,241

Medicare Intermediary Novitas Solutions

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/2017 Fiscal Year: 06/30/2017

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

Facility Name & ID Number Rosewood Care Center Of Elgin # 0049346 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		6,115	479,520	485,635	485,635		485,635			1
2	Food Purchase		253,358		253,358	253,358	(9,343)	244,015			2
3	Housekeeping		24,133	192,597	216,730	216,730		216,730			3
4	Laundry			128,398	128,398	128,398		128,398			4
5	Heat and Other Utilities			189,809	189,809	189,809	(12,263)	177,546			5
6	Maintenance	37,743	7,750	277,401	322,894	322,894	(39,535)	283,359			6
7	Other (specify):*						5,432	5,432			7
8	TOTAL General Services	37,743	291,356	1,267,725	1,596,824	1,596,824	(55,709)	1,541,115			8
	B. Health Care and Programs										
9	Medical Director			11,000	11,000	11,000		11,000			9
10	Nursing and Medical Records	3,475,213	305,305	67,750	3,848,268	3,848,268	46,105	3,894,373			10
10a	Therapy	196,177	1,073		197,250	197,250		197,250			10a
11	Activities	69,617	4,299	2,524	76,440	76,440		76,440			11
12	Social Services	96,308		2,200	98,508	98,508		98,508			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*						3,201	3,201			15
16	TOTAL Health Care and Programs	3,837,315	310,677	83,474	4,231,466	4,231,466	49,306	4,280,772			16
	C. General Administration										
17	Administrative	106,758		451,178	557,936	557,936	(410,867)	147,069			17
18	Directors Fees										18
19	Professional Services			264,125	264,125	264,125	(32,905)	231,220			19
20	Dues, Fees, Subscriptions & Promotions			18,404	18,404	18,404	(178)	18,226			20
21	Clerical & General Office Expenses	151,030	28,708	422,398	602,136	602,136	(164,370)	437,766			21
22	Employee Benefits & Payroll Taxes			597,481	597,481	597,481		597,481			22
23	Inservice Training & Education										23
24	Travel and Seminar			2,502	2,502	2,502	1,511	4,013			24
25	Other Admin. Staff Transportation			1,689	1,689	1,689	12,855	14,544			25
26	Insurance-Prop.Liab.Malpractice			93,593	93,593	93,593	16,402	109,995			26
27	Other (specify):*						30,882	30,882			27
28	TOTAL General Administration	257,788	28,708	1,851,370	2,137,866	2,137,866	(546,669)	1,591,197			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,132,846	630,741	3,202,569	7,966,156	7,966,156	(553,071)	7,413,085			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 Elgin

#0049346

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			13,690	13,690		13,690	95,470	109,160			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			161,688	161,688		161,688	(34,252)	127,436			32
33	Real Estate Taxes							144,943	144,943			33
34	Rent-Facility & Grounds			906,657	906,657		906,657	(881,890)	24,767			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			21,252	21,252		21,252	46,453	67,705			36
37	TOTAL Ownership			1,103,287	1,103,287		1,103,287	(629,275)	474,012			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		479,301	873,044	1,352,345		1,352,345		1,352,345			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			275,909	275,909		275,909		275,909			42
43	Other (specify):*	113,958		1,815	115,773		115,773	(115,773)				43
44	TOTAL Special Cost Centers	113,958	479,301	1,150,768	1,744,027		1,744,027	(115,773)	1,628,254			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,246,804	1,110,042	5,456,624	10,813,470		10,813,470	(1,298,119)	9,515,351			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	(1,241)	02		4
5	Telephone, TV & Radio in Resident Rooms	(12,793)	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	(122,379)	30		9
10	Interest and Other Investment Income	(334,831)	32		10
11	Discounts, Allowances, Rebates & Refunds	(7,037)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(959)	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	(4,563)	21		18
19	Entertainment	(110)	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	(314,870)	21		24
25	Fund Raising, Advertising and Promotional	(71)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(478)	20		28
29	Other-Attach Schedule	(231,614)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,030,946)		\$	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)	(267,173)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (267,173)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,298,119)		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 Elgin

ID# 0049346

Report Period Beginning: 07/01/16

Ending: 06/30/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Marketing Salary (Bravo and Team Health)	\$ (113,958)	43	1
2	Marketing	(1,815)	43	2
3	Bank Charges	(2,814)	21	3
4	Vending Income	(106)	02	4
5	MidCap Line of Credit Fees	(21,252)	36	5
6	Vendor Late Charges	(53,933)	21	6
7	PAC Dues	(3,513)	20	7
8	Non Allowable Legal Fees	(2,223)	19	8
9	Bldg Co - Professional Fees	(9,915)	19	9
10	Bldg Co - Loan Fee	(6,089)	36	10
11	Bldg Co - Bank Charges	(12,282)	21	11
12	Capitalized R&M	(3,135)	06	12
13	Non-Allowable Marketing Travel	(579)	25	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(231,614)		49

Rosewood Care Center Of Elgin

Report Period Beginning: 07/01/16
 Ending: 06/30/17
 ID# 0049346

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	Total		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Center Of Elgin# 0049346

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	(9,343)											(9,343)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(12,793)					302	228					(12,263)	5
6	Maintenance	(3,135)					131	(36,531)					(39,535)	6
7	Other (specify):*							5,432					5,432	7
8	TOTAL General Services	(25,271)					432	(30,870)					(55,709)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				46,105								46,105	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				3,201								3,201	15
16	TOTAL Health Care and Programs				49,306								49,306	16
	C. General Administration													
17	Administrative				(97,689)		(313,178)						(410,867)	17
18	Directors Fees													18
19	Professional Services	(12,138)	9,915	18,971	459	(50,112)							(32,905)	19
20	Fees, Subscriptions & Promotions	(4,062)			5	93	3,675	111					(178)	20
21	Clerical & General Office Expenses	(388,572)	19,482		1,077	14,432	188,472	739					(164,370)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			979	152	199	181						1,511	24
25	Other Admin. Staff Transportation	(579)			3,766	1,380	4,486	3,802					12,855	25
26	Insurance-Prop.Liab.Malpractice		9,983				5,415	1,005					16,402	26
27	Other (specify):*				4,358	1,679	24,846						30,882	27
28	TOTAL General Administration	(405,351)	39,380	19,950	(87,873)	(32,328)	(86,105)	5,657					(546,669)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(430,622)	39,380	19,950	(38,567)	(32,328)	(85,672)	(25,213)					(553,071)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Center Of Elgin # 0049346 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	(122,379)	202,457				14,737	655					95,470	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(334,831)	317,642	(43,771)			26,709						(34,252)	32
33	Real Estate Taxes		144,943										144,943	33
34	Rent-Facility & Grounds		(902,446)				20,556						(881,890)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*	(27,341)	73,794										46,453	36
37	TOTAL Ownership	(484,551)	(163,610)	(43,771)			62,002	655					(629,275)	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):*	(115,773)											(115,773)	43
44	TOTAL Special Cost Centers	(115,773)											(115,773)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,030,946)	(124,230)	(23,821)	(38,567)	(32,328)	(23,670)	(24,557)					(1,298,119)	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	\$ 902,446	Elgin Real Estate, LLC		\$	\$ (902,446)	1
2	V	32 Interest Income - Escrow	45	Elgin Real Estate, LLC			(45)	2
3	V	19 Audit Fees - HB&CO		Elgin Real Estate, LLC		9,720	9,720	3
4	V	19 Professional Fees		Elgin Real Estate, LLC		195	195	4
5	V	21 Bank Charges		Elgin Real Estate, LLC		12,282	12,282	5
6	V	32 Int Expense - HUD Mortgage		Elgin Real Estate, LLC		317,687	317,687	6
7	V	36 Int Expense - HUD MIP		Elgin Real Estate, LLC		67,705	67,705	7
8	V	33 Real Estate Taxes		Elgin Real Estate, LLC		144,943	144,943	8
9	V	30 Depreciation		Elgin Real Estate, LLC		202,457	202,457	9
10	V	36 Amortization Loan Fee		Elgin Real Estate, LLC		6,089	6,089	10
11	V	21 Base Admin Fee		Elgin Real Estate, LLC		7,200	7,200	11
12	V	26 Insurance Expense - Property		Elgin Real Estate, LLC		9,983	9,983	12
13	V							13
14	Total		\$ 902,491			\$ 778,261	\$ * (124,230)	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%	\$ 18,971	\$	18,971	15
16	V	24 SEMINAR EXPENSE		BRAVO HOLDING COMPANY	100.00%	979		979	16
17	V	32 INTEREST		BRAVO HOLDING COMPANY	100.00%	(43,771)		(43,771)	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		\$			\$ (23,821)	\$ *	(23,821)	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%	\$ 46,105	\$	46,105	15
16	V	15 CORPORATE RN SALARIES BENEFITS		BRAVO NURSING HOME SERVICES, INC.	100.00%	3,201		3,201	16
17	V	17 ADMINISTRATIVE SALARIES		BRAVO NURSING HOME SERVICES, INC.	100.00%	40,311		40,311	17
18	V	19 PROFESSIONAL FEES		BRAVO NURSING HOME SERVICES, INC.	100.00%	459		459	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%	1,077		1,077	20
21	V	24 SEMINAR & LODGING EXPENSE		BRAVO NURSING HOME SERVICES, INC.	100.00%	152		152	21
22	V	25 AUTO EXPENSE		BRAVO NURSING HOME SERVICES, INC.	100.00%	3,766		3,766	22
23	V	27 ADMINISTRATIVE & OFFICE BENEFITS		BRAVO NURSING HOME SERVICES, INC.	100.00%	4,358		4,358	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			\$ 99,433	\$ *	(38,567)	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%	\$ 1,266	\$ 1,266
16	V	20 LICENSES		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	93	93
17	V	21 LEGAL SALARIES		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	14,240	14,240
18	V	21 OFFICE EXPENSE		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	192	192
19	V	24 SEMINAR		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	199	199
20	V	25 AUTO / TRAVEL EXPENSE		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	1,380	1,380
21	V	27 EMPLOYEE BENEFITS		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	1,679	1,679
22	V						
23	V	19 PROFESSIONAL FEES	51,378	CLAIMS ADMINISTRATION SERVICES, LLC	100.00%		(51,378)
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 51,378			\$ 19,050	\$ * (32,328)

* 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%	\$ 302	\$	302	15
16	V	6 MAINTENANCE EXPENSE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	131		131	16
17	V	20 DUES, SUBSCRIPTIONS, LICENSES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	3,675		3,675	17
18	V	21 OFFICE SALARIES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	147,969		147,969	18
19	V	21 OFFICE EXPENSES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	47,703		47,703	19
20	V	24 SEMINAR		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	181		181	20
21	V	25 TRAVEL EXPENSE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	4,486		4,486	21
22	V	26 INSURANCE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	5,415		5,415	22
23	V	27 EMPLOYEE BENEFITS		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	24,846		24,846	23
24	V	30 DEPRECIATION		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	14,737		14,737	24
25	V	32 INTEREST		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	26,709		26,709	25
26	V	34 BUILDING RENT		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	20,556		20,556	26
27	V								27
28	V								28
29	V	17 ADMINISTRATIVE FEE	313,178	MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%			(313,178)	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		\$ 320,378			\$ 296,708	\$ *	(23,670)	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%	\$ 228	\$	228	15
16	V	6 MAINTENANCE SALARY		SENIOR LIVING SERVICES, INC.	100.00%	36,170		36,170	16
17	V	6 MAINTENANCE EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	3,242		3,242	17
18	V	7 MAINTENANCE BENEFITS		SENIOR LIVING SERVICES, INC.	100.00%	5,432		5,432	18
19	V	20 LICENSES		SENIOR LIVING SERVICES, INC.	100.00%	111		111	19
20	V	21 OFFICE EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	739		739	20
21	V	25 AUTO / TRAVEL EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	3,802		3,802	21
22	V	26 INSURANCE		SENIOR LIVING SERVICES, INC.	100.00%	1,005		1,005	22
23	V	30 DEPRECIATION		SENIOR LIVING SERVICES, INC.	100.00%	655		655	23
24	V								24
25	V	6 MAINTENANCE SERVICES	76,302	SENIOR LIVING SERVICES, INC.	100.00%	360		(75,942)	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		\$ 76,302			\$ 51,745	\$ *	(24,557)	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 Elgin # 0049346 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	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	\$		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 Elgin

0049346

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 Elgin

0049346

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 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	19	PROFESSIONAL FEES	PATIENT DAYS	445,412	14	\$ 210,656	\$ 40,112	\$ 18,971	1
2	24	SEMINAR EXPENSE	PATIENT DAYS	445,412	14	10,876	40,112	979	2
3	32	INTEREST	PATIENT DAYS	445,412	14	(486,047)	40,112	(43,771)	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)	\$	\$ (23,821)	25

Facility Name & ID Number Rosewood Care Center Of Elgin

0049346

Report Period Beginning:

07/01/16

Ending: 06/30/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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	10	CORPORATE RN SALARIES	PAT. DAYS	445,412	14	\$ 511,965	\$ 40,112	\$ 46,105	1
2	15	CORPORATE RN SALARIES BI	PAT. DAYS	445,412	14	35,539	40,112	3,201	2
3	17	ADMINISTRATIVE SALARIES	PAT. DAYS	445,412	14	447,622	40,112	40,311	3
4	19	PROFESSIONAL FEES	PAT. DAYS	445,412	14	5,100	40,112	459	4
5	20	DUES & SUBSCRIPTIONS	PAT. DAYS	445,412	14	53	40,112	5	5
6	21	OFFICE EXPENSES	PAT. DAYS	445,412	14	11,963	40,112	1,077	6
7	24	SEMINAR & LODGING EXPEN	PAT. DAYS	445,412	14	1,683	40,112	152	7
8	25	AUTO EXPENSE	PAT. DAYS	445,412	14	41,816	40,112	3,766	8
9	27	ADMINISTRATIVE & OFFICE I	PAT. DAYS	445,412	14	48,387	40,112	4,358	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	\$ 99,433	25

Facility Name & ID Number Rosewood Care Center Of Elgin

0049346

Report Period Beginning:

07/01/16

Ending: 06/30/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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	ACTUAL FEES	439,804	14	\$ 15,685	\$ 35,504	\$ 1,266	1
2	20	LICENSES	ACTUAL FEES	439,804	14	1,155	35,504	93	2
3	21	LEGAL SALARIES	ACTUAL FEES	439,804	14	176,396	176,396	14,240	3
4	21	OFFICE EXPENSE	ACTUAL FEES	439,804	14	2,382	35,504	192	4
5	24	SEMINAR	ACTUAL FEES	439,804	14	2,470	35,504	199	5
6	25	AUTO / TRAVEL EXPENSE	ACTUAL FEES	439,804	14	17,094	35,504	1,380	6
7	27	EMPLOYEE BENEFITS	ACTUAL FEES	439,804	14	20,803	35,504	1,679	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	\$ 19,050	25

Facility Name & ID Number Rosewood Care Center Of Elgin

0049346

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	\$ 40,112	\$ 302	1
2	6	MAINTENANCE EXPENSE	PAT. DAYS	445,412	14	1,452	40,112	131	2
3	20	DUES, SUBSCRIPTIONS, LICEN	PAT. DAYS	445,412	14	40,807	40,112	3,675	3
4	21	OFFICE SALARIES	PAT. DAYS	445,412	14	1,643,080	1,643,080	147,969	4
5	21	OFFICE EXPENSES	PAT. DAYS	445,412	14	529,702	40,112	47,703	5
6	24	SEMINAR	PAT. DAYS	445,412	14	2,006	40,112	181	6
7	25	TRAVEL EXPENSE	PAT. DAYS	445,412	14	49,808	40,112	4,486	7
8	26	INSURANCE	PAT. DAYS	445,412	14	60,126	40,112	5,415	8
9	27	EMPLOYEE BENEFITS	PAT. DAYS	445,412	14	275,890	40,112	24,846	9
10	30	DEPRECIATION	PAT. DAYS	445,412	14	163,642	40,112	14,737	10
11	32	INTEREST	PAT. DAYS	445,412	14	296,581	40,112	26,709	11
12	34	BUILDING RENT	PAT. DAYS	445,412	14	228,258	40,112	20,556	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	\$ 296,708	25

Facility Name & ID Number Rosewood Care Center Of Elgin

0049346

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	931,614	14	\$ 2,789	\$ 76,302	\$ 228	1
2	6	MAINTENANCE SALARY	ACTUAL FEES	931,614	14	441,618	441,618	36,170	2
3	6	MAINTENANCE EXPENSE	ACTUAL FEES	931,614	14	39,580	76,302	3,242	3
4	7	MAINTENANCE BENEFITS	ACTUAL FEES	931,614	14	66,326	76,302	5,432	4
5	20	LICENSES	ACTUAL FEES	931,614	14	1,361	76,302	111	5
6	21	OFFICE EXPENSE	ACTUAL FEES	931,614	14	9,024	76,302	739	6
7	25	AUTO / TRAVEL EXPENSE	ACTUAL FEES	931,614	14	46,424	76,302	3,802	7
8	26	INSURANCE	ACTUAL FEES	931,614	14	12,265	76,302	1,005	8
9	30	DEPRECIATION	ACTUAL FEES	931,614	14	8,001	76,302	655	9
10									10
11	6	MAINTENANCE SERVICES	DIRECT ALLOCATION		14	4,421		360	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	\$ 51,745	25

Facility Name & ID Number Rosewood Care Center Of Elgin

0049346

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 Elgin

0049346

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 Elgin

0049346 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 Elgin

0049346

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

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	\$72,580.21	08/01/04	\$ 5,558,983	\$ 13,338,514	09/01/39	0.0239	\$ 317,687	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	MidCap		X	Line of Credit							161,688	6								
7	Alloc. - Midwest Admin Svcs										26,709	7								
8												8								
9	TOTAL Facility Related				\$72,580.21		\$ 5,558,983	\$ 13,338,514			\$ 506,084	9								
B. Non-Facility Related*																				
10	Interest Income										(334,831)	10								
11	Interest Income - Bldg Co										(45)	11								
12	Alloc. Bravo Holding Co.										(43,771)	12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (378,647)	14								
15	TOTALS (line 9+line14)						\$ 5,558,983	\$ 13,338,514			\$ 127,437	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 67,705 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.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2016 report.		\$	113,613	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	144,235	2
3. Under or (over) accrual (line 2 minus line 1).		\$	30,622	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	114,321	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	144,943	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2012	109,448	8
	2013	100,985	9
	2014	121,313	10
	2015	143,991	11
	2016	144,479	12

Accrual Base on prior year tax bill

Line 2 reflects the 2nd installment of the 2015 tax bill and the 1st installment of the 2016 tax bill.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2016	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

Facility Name & ID Number Rosewood Care Center Of Elgin

0049346 Report Period Beginning:

07/01/16 Ending:

06/30/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,268 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>206,817</u>	<u>2013</u>	<u>\$ 590,758</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	206,817		\$ 590,758	3

Facility Name & ID Number Rosewood Care Center Of Elgin

0049346

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	139		2013	1994	\$ 2,778,942	\$ 202,457	40	\$ 69,474	\$ (132,983)	\$ 243,159	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		2009		2,785		20	165	165	2,785	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 Elgin

0049346

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	
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		80,395			6,268	6,268	19,384	67
68		321	64		64		64	68
69			13,690			(13,690)		69
70		\$ 2,862,443	\$ 216,211		\$ 75,971	\$ (140,240)	\$ 265,392	70

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

Facility Name & ID Number Rosewood Care Center Of Elgin

0049346

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 12A, Carried Forward	\$ 2,862,443	\$ 216,211		\$ 75,971	\$ (140,240)	\$ 265,392	1	
2	Design Dev. Including Architectual, Structural, Mechanical,	2014	8,071		20	1,153	1,153	3,363	2
3	Electrical & Interior Design. Review Of Infrastructure.	2014			20				3
4	Replace Wallcoverings Main Dining & Assisted Dining Rooms	2014	7,909		20	1,130	1,130	3,202	4
5	Diagnose/Replace Cable Wires For Fax Machine	2015	4,326		20	216	216	433	5
6	Control Board Kit/Capacitor/Motor	2015	2,582		20	129	129	258	6
7	Control Board Kit/Circuit Board/Dc Relay Assembly/ Thermostat	2016	4,039		20	202	202	404	7
8	Compressor Rotary/Reversing Valve/Solenoid Coil & Motor 1/4 H	2016	2,742		20	137	137	274	8
9	Replaced Damaged Eifs On East And West Arches.	2016	3,135		20	157	157	157	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)	\$ 2,895,248	\$ 216,211		\$ 79,095	\$ (137,116)	\$ 273,483		34

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

Facility Name & ID Number Rosewood Care Center Of Elgin

0049346

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		\$ 2,895,248	\$ 216,211		\$ 79,095	\$ (137,116)	\$ 273,483	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		\$ 2,895,248	\$ 216,211		\$ 79,095	\$ (137,116)	\$ 273,483	34

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

Facility Name & ID Number Rosewood Care Center Of Elgin

0049346

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		\$ 2,895,248	\$ 216,211		\$ 79,095	\$ (137,116)	\$ 273,483	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		\$ 2,895,248	\$ 216,211		\$ 79,095	\$ (137,116)	\$ 273,483	34

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

Facility Name & ID Number Rosewood Care Center Of Elgin

0049346

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		\$ 2,895,248	\$ 216,211		\$ 79,095	\$ (137,116)	\$ 273,483	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		\$ 2,895,248	\$ 216,211		\$ 79,095	\$ (137,116)	\$ 273,483	34

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

Facility Name & ID Number Rosewood Care Center Of Elgin

0049346

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	Boiler Replacement	2013	2,954		40	74	74	265	9
10	Drain Piping	2014	3,989		40	100	100	342	10
11	Cat Iron Drain	2014	3,324		40	83	83	284	11
12	HVAC Improvements	2014	5,310		10	531	531	1,859	12
13	Sprinkler	2014	47,526		10	4,753	4,753	14,655	13
14	Seal Coating	2014	6,062		25	242	242	666	14
15	Replaced Water Source Heat Pump - 200 Corridor	2014	2,730		10	273	273	728	15
16	Roof Repairs - Kitchen / Dining Room	2014	8,500		40	213	213	585	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)		\$ 80,395	\$		\$ 6,268	\$ 6,268	\$ 19,384	34

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

Facility Name & ID Number Rosewood Care Center Of Elgin

0049346

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		\$ 80,395	\$		\$ 6,268	\$	\$ 19,384	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)	\$ 80,395	\$		\$ 6,268	\$	\$ 19,384	34

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

Facility Name & ID Number Rosewood Care Center Of Elgin

0049346

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	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	Allocated from Senior Living Services	2017	321	64	5	64		64	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)		\$ 321	\$ 64		\$ 64	\$	\$ 64	34

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

Facility Name & ID Number Rosewood Care Center Of Elgin

0049346

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		\$ 321	\$ 64		\$ 64	\$	\$ 64	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)	\$ 321	\$ 64		\$ 64	\$	\$ 64	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	\$ 101,986	\$ 3,316	\$ 17,429	\$ 14,113	10	\$ 65,999	71
72	Current Year Purchases	6,236		624	624	10	624	72
73	Fully Depreciated Assets	22,330	118	118		10	22,330	73
74								74
75	TOTALS	\$ 130,552	\$ 3,434	\$ 18,171	\$ 14,737		\$ 88,953	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 Midwest Adminis	various	\$ 60,432	\$ 11,303	\$ 11,303		5	\$ 49,744	76
77		Allocated from Senior Living Ser	various	12,259	591	591		5	12,062	77
78										78
79										79
80	TOTALS			\$ 72,691	\$ 11,894	\$ 11,894			\$ 61,806	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)	\$ 3,689,248	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 231,539	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 109,160	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (122,379)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 424,242	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.

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				4,211			5
6	Allocated from Midwest Admin Services, Inc				20,556			6
7	TOTAL				\$ 24,767			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: \$ _____ 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			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Rosewood Care Center Of Elgin # 0049346 Report Period Beginning: 07/01/16 Ending: 06/30/17

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		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units	Cost			Units	Cost								
1	Licensed Occupational Therapist	39 - 03	hrs	\$				\$	353,805	\$			\$		353,805	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs						120,317						120,317	2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	39 - 03	hrs						362,372						362,372	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 prescripts								469,530				469,530	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify):															12
13	Other (specify):								36,550		9,771				46,321	13
14	TOTAL			\$				\$	873,044	\$	479,301		\$		1,352,345	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	\$ 1,193	\$ 2,288	1
2	Cash-Patient Deposits	500	500	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,478,617	2,478,617	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	53,202	56,926	6
7	Other Prepaid Expenses	4,447	174,803	7
8	Accounts Receivable (owners or related parties)	7,386,594	7,386,894	8
9	Other(specify): <u>See Attached Schedule</u>	2,000	2,300	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 9,926,553	\$ 10,102,328	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		590,758	13
14	Buildings, at Historical Cost		4,590,032	14
15	Leasehold Improvements, at Historical Cost	18,765	620,145	15
16	Equipment, at Historical Cost	59,324	905,765	16
17	Accumulated Depreciation (book methods)	(58,042)	(3,715,999)	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)	\$ 20,047	\$ 2,990,701	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,946,600	\$ 13,093,029	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 3,470,840	\$ 3,677,944	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	255,309	255,309	30
31	Accrued Taxes Payable (excluding real estate taxes)	316,699	316,699	31
32	Accrued Real Estate Taxes(Sch.IX-B)		114,321	32
33	Accrued Interest Payable		671,560	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	9,212	9,212	35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	3,132,212	427,351	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,184,272	\$ 5,472,396	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		13,338,514	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)	\$	\$ 13,338,514	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,184,272	\$ 18,810,910	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,762,328	\$ (5,717,881)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,946,600	\$ 13,093,029	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,833,301	1
2	Restatements (describe):		2
3	Equity Adjustment	3	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,833,304	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(70,976)	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)	\$ (70,976)	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)	\$ 2,762,328	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Rosewood Care Center Of Elgin

0049346

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	\$ 10,131,337	1
2	Discounts and Allowances for all Levels	(1,866,772)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,264,565	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,592,725	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,592,725	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,800	13
14	Non-Patient Meals	1,241	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	382,852	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	130,340	19
20	Radiology and X-Ray	25,241	20
21	Other Medical Services	1,755	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 543,229	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	334,831	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 334,831	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	7,144	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,144	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,742,494	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,596,824	31
32	Health Care	4,231,466	32
33	General Administration	2,137,866	33
B. Capital Expense			
34	Ownership	1,103,287	34
C. Ancillary Expense			
35	Special Cost Centers	1,468,118	35
36	Provider Participation Fee	275,909	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,813,470	40
41	Income before Income Taxes (line 30 minus line 40)**	(70,976)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (70,976)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,729,009	44
45	Private Pay - Net Inpatient Revenue	3,993,612	45
46	Medicare - Net Inpatient Revenue	1,319,513	46
47	Other-(specify)	1,222,431	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,264,565	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 Elgin

0049346

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	1,978	2,175	\$ 97,293	\$ 44.73	1
2	Assistant Director of Nursing	1,573	1,692	67,281	39.76	2
3	Registered Nurses	42,935	46,178	1,431,191	30.99	3
4	Licensed Practical Nurses	22,175	24,260	614,012	25.31	4
5	CNAs & Orderlies	91,276	96,276	1,195,778	12.42	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,369	8,982	196,177	21.84	8
9	Activity Director	2,147	2,314	37,193	16.07	9
10	Activity Assistants	3,171	3,409	32,424	9.51	10
11	Social Service Workers	3,872	4,266	96,308	22.58	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	2,193	2,460	37,743	15.34	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,066	2,222	106,758	48.05	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,920	10,550	151,030	14.32	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	4,010	4,311	69,658	16.16	31
32	Other Health Care(specify)					32
33	Other(specify)	6,125	6,453	113,958	17.66	33
34	TOTAL (lines 1 - 33)	201,810	215,548	\$ 4,246,804 *	\$ 19.70	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	11,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,730	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	2,524	11-03	44
45	Social Service Consultant	Monthly	2,200	12-03	45
46	Other(specify) <u>Outsourced Dietary</u>	Monthly	479,520	01-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 505,974		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	40	\$ 2,386	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	2,185	54,634	10-03	52
53	TOTAL (lines 50 - 52)	2,225	\$ 57,020		53

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

0049346

Report Period Beginning: **07/01/16**

Ending: **06/30/17**

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	
Peggy Aschenbenner	Administrator	0	\$ 106,758	Workers' Compensation Insurance	\$ 124,312	IDPH License Fee	\$ 3,980	
				Unemployment Compensation Insurance	34,806	Advertising: Employee Recruitment	1,491	
				FICA Taxes	315,203	Health Care Worker Background Check		
				Employee Health Insurance	89,593	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	5,381	
				Other Health Insurance Expense	4,677	State Police Reports	3,490	
				Dental Insurance	3,560	Allocated from Bravo Nursing Home Svcs	5	
				Employee Relations	4,934	Allocated from Midwest Administrative Svcs	3,675	
				401K Expense	17,032	See Supplemental Schedule	204	
				Employee Physicals	3,070	Less: Public Relations Expense (_____)		
				Employee Drug Test	294	Non-allowable advertising (_____)		
						Yellow page advertising (_____)		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 106,758	TOTAL (agree to Schedule V, line 22, col.8)		\$ 18,226		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Mgmt Fees - Bravo Nursing Home Services			\$ 138,000				Out-of-State Travel	\$ _____
Mgmt Fees - Midwest Admin Services			313,178					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 451,178				In-State Travel	
C. Professional Services				TOTAL			Seminar Expense	
Vendor/Payee	Type		Amount	\$ _____			2,502	
Marcum, LLP	Accounting		\$ 10,199				Allocated from Bravo Holding Co	
Ability Network	Software		6,999				979	
Quality Healthcare	Financial Services		160,301				Allocated from Bravo Nursing Home Svcs	
Resolute Healthcare Solutions	Human Resources		4,831				152	
Claims Administration Services	Related Party Legal Fees		51,378				See Supplemental Schedule	
Infinite Solutions Support Charges	Technology Consulting		24,929				380	
See Attached	Legal Fees		5,401				Entertainment Expense (_____)	
Assurance Agency	Risk Management		87				(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 264,125				TOTAL	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Rosewood Care Center Of Elgin# 0049346Report 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. Illinois Healthcare Assoc \$8894
- (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
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 71,189 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. \$ 275,909
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. \$ 1,241
- (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