



Facility Name & ID Number Rosewood Care Center Of Rockford

# 0049270 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	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	16,171	5,706	8,465	30,342	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,171	5,706	8,465	30,342	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.27%

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 58 and days of care provided 6,672

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: 6/30/17 Fiscal Year: 6/30/17

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

Facility Name & ID Number Rosewood Care Center Of Rockford # 0049270 Report Period Beginning: 07/01/16 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
	<b>A. General Services</b>										
1	Dietary		179	382,992	383,171	383,171		383,171			1
2	Food Purchase		206,541		206,541	206,541	(12,876)	193,665			2
3	Housekeeping		12,781	173,499	186,280	186,280		186,280			3
4	Laundry			115,666	115,666	115,666		115,666			4
5	Heat and Other Utilities			130,671	130,671	130,671	(8,560)	122,111			5
6	Maintenance	39,979	10,441	213,371	263,791	263,791	(25,085)	238,706			6
7	Other (specify):*						3,319	3,319			7
8	<b>TOTAL General Services</b>	<b>39,979</b>	<b>229,942</b>	<b>1,016,199</b>	<b>1,286,120</b>	<b>1,286,120</b>	<b>(43,202)</b>	<b>1,242,918</b>			<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			7,700	7,700	7,700		7,700			9
10	Nursing and Medical Records	1,924,507	237,900	509,432	2,671,839	2,671,839	34,604	2,706,443			10
10a	Therapy	103,766	672		104,438	104,438		104,438			10a
11	Activities	60,087	5,691	2,600	68,378	68,378		68,378			11
12	Social Services	62,720		2,600	65,320	65,320		65,320			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*						2,421	2,421			15
16	<b>TOTAL Health Care and Programs</b>	<b>2,151,080</b>	<b>244,263</b>	<b>522,332</b>	<b>2,917,675</b>	<b>2,917,675</b>	<b>37,025</b>	<b>2,954,700</b>			<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	101,818		388,321	490,139	490,139	(357,828)	132,311			17
18	Directors Fees										18
19	Professional Services			112,975	112,975	112,975	(10,076)	102,899			19
20	Dues, Fees, Subscriptions & Promotions			23,205	23,205	23,205	116	23,321			20
21	Clerical & General Office Expenses	126,052	19,588	283,585	429,225	429,225	(91,473)	337,752			21
22	Employee Benefits & Payroll Taxes			335,916	335,916	335,916		335,916			22
23	Inservice Training & Education										23
24	Travel and Seminar			3,555	3,555	3,555	1,216	4,771			24
25	Other Admin. Staff Transportation			3,749	3,749	3,749	8,678	12,427			25
26	Insurance-Prop.Liab.Malpractice			80,800	80,800	80,800	13,892	94,692			26
27	Other (specify):*						23,978	23,978			27
28	<b>TOTAL General Administration</b>	<b>227,870</b>	<b>19,588</b>	<b>1,232,106</b>	<b>1,479,564</b>	<b>1,479,564</b>	<b>(411,496)</b>	<b>1,068,068</b>			<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,418,929</b>	<b>493,793</b>	<b>2,770,637</b>	<b>5,683,359</b>	<b>5,683,359</b>	<b>(417,673)</b>	<b>5,265,686</b>			<b>29</b>

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

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

Facility Name &amp; ID Number

Rosewood Care Center Of Rockford

#0049270

Report Period Beginning:

07/01/16

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	
	<b>D. Ownership</b>											
30	Depreciation			10,311	10,311		10,311	82,915	93,226			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			264,280	264,280		264,280	429,840	694,120			32
33	Real Estate Taxes							126,803	126,803			33
34	Rent-Facility & Grounds			957,116	957,116		957,116	(937,586)	19,530			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			16,131	16,131		16,131	32,175	48,306			36
37	<b>TOTAL Ownership</b>			1,247,838	1,247,838		1,247,838	(265,852)	981,986			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		353,777	884,279	1,238,056		1,238,056		1,238,056			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			208,930	208,930		208,930		208,930			42
43	Other (specify):*	103,551		2,233	105,784		105,784	(105,784)	(0)			43
44	<b>TOTAL Special Cost Centers</b>	103,551	353,777	1,095,442	1,552,770		1,552,770	(105,784)	1,446,986			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	2,522,480	847,570	5,113,917	8,483,967		8,483,967	(789,310)	7,694,657			45

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

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,400)	02		4
5	Telephone, TV & Radio in Resident Rooms	(8,928)	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	(93,441)	30		9
10	Interest and Other Investment Income	(78)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(388)	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	(3,678)	21		18
19	Entertainment	(213)	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	(209,112)	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	(205)	20		28
29	Other-Attach Schedule	(211,679)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (532,122)		\$	30

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(257,188)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (257,188)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (789,310)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

**C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)**

		1	2	3	4	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

**BHF USE ONLY**

48		49		50		51		52	
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Rosewood Care Center Of Rockford

ID# 0049270

Report Period Beginning: 07/01/16

Ending: 06/30/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non Allowable Travel	\$ (1,438)	25	1
2	Marketing Salary	(103,551)	43	2
3	Marketing Expense	(2,233)	43	3
4	Resident Reimbursement	(272)	10	4
5	Vendor Discount	(6,075)	02	5
6	Miscellaneous Income	(2,979)	21	6
7	Vendor Late Charges	(38,375)	21	7
8	Bank Charges	(2,621)	21	8
9	Vending Income	(2,013)	02	9
10	Midcap Credit Fees	(16,131)	36	10
11	PAC Dues	(2,635)	20	11
12	Non Allowable Legal Fees	(2,564)	19	12
13	Capitalized R&M	(2,890)	06	13
14	Bldg. Co. - Audit Fees	(9,720)	19	14
15	Bldg.Co.- Bank Fees	(13,322)	21	15
16	Bldg. Co.-Amortization	(4,859)	36	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	<b>Total</b>	(211,679)		49

Rosewood Care Center Of Rockford

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

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

## STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

07/01/16

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	(12,876)											(12,876)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(8,928)					228	140					(8,560)	5
6	Maintenance	(2,890)					99	(22,294)					(25,085)	6
7	Other (specify):*							3,319					3,319	7
8	<b>TOTAL General Services</b>	<b>(24,694)</b>					<b>327</b>	<b>(18,835)</b>					<b>(43,202)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(272)			34,876								34,604	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				2,421								2,421	15
16	<b>TOTAL Health Care and Programs</b>	<b>(272)</b>			<b>37,297</b>								<b>37,025</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative				(107,507)		(250,321)						(357,828)	17
18	Directors Fees													18
19	Professional Services	(12,284)	9,720	14,350	347	(22,209)							(10,076)	19
20	Fees, Subscriptions & Promotions	(2,840)			4	105	2,780	68					116	20
21	Clerical & General Office Expenses	(270,301)	20,522		815	16,227	140,812	452					(91,473)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			741	115	224	137						1,216	24
25	Other Admin. Staff Transportation	(1,438)			2,849	1,552	3,393	2,323					8,678	25
26	Insurance-Prop.Liab.Malpractice		9,182				4,096	614					13,892	26
27	Other (specify):*				3,296	1,888	18,794						23,978	27
28	<b>TOTAL General Administration</b>	<b>(286,863)</b>	<b>39,424</b>	<b>15,091</b>	<b>(100,082)</b>	<b>(2,213)</b>	<b>(80,309)</b>	<b>3,457</b>					<b>(411,496)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(311,829)</b>	<b>39,424</b>	<b>15,091</b>	<b>(62,785)</b>	<b>(2,213)</b>	<b>(79,982)</b>	<b>(15,379)</b>					<b>(417,673)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Center Of Rockford # 0049270 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	(93,441)	164,808				11,147	400					82,915	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(78)	442,825	(33,110)			20,203						429,840	32
33	Real Estate Taxes		126,803										126,803	33
34	Rent-Facility & Grounds		(953,135)				15,549						(937,586)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*	(20,990)	53,165										32,175	36
37	<b>TOTAL Ownership</b>	<b>(114,509)</b>	<b>(165,534)</b>	<b>(33,110)</b>			<b>46,900</b>	<b>400</b>					<b>(265,852)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(105,784)											(105,784)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(105,784)</b>											<b>(105,784)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(532,122)</b>	<b>(126,110)</b>	<b>(18,019)</b>	<b>(62,785)</b>	<b>(2,213)</b>	<b>(33,082)</b>	<b>(14,978)</b>					<b>(789,310)</b>	<b>45</b>

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Pg 6 Supplemental		See Pg 6 Supplemental		See Pg 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: 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		
1	V	34 Rental Income	\$ 953,135	Rockford Real Estate	100.00%	\$	(953,135)	1
2	V	32 Interest	14	Rockford Real Estate	100.00%	442,839	442,825	2
3	V	19 Audit Fees		Rockford Real Estate	100.00%	9,720	9,720	3
4	V	21 Bank Charges		Rockford Real Estate	100.00%	13,322	13,322	4
5	V	36 Interest - HUD MIP		Rockford Real Estate	100.00%	48,306	48,306	5
6	V	33 Real Estate Tax		Rockford Real Estate	100.00%	126,803	126,803	6
7	V	30 Depreciation		Rockford Real Estate	100.00%	164,808	164,808	7
8	V	36 Amortization Loan Fee		Rockford Real Estate	100.00%	4,859	4,859	8
9	V	21 Base Admin Fee (Pg 6D)		Rockford Real Estate	100.00%	7,200	7,200	9
10	V	26 Insurance Expense - Property		Rockford Real Estate	100.00%	9,182	9,182	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 953,149			\$ 827,039	\$ * (126,110)	14

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

Facility Name & ID Number

Rosewood Care Center Of Rockford

# 0049270

Report Period Beginning:

07/01/16

Ending:

06/30/17

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%	\$ 14,350	\$	14,350	15
16	V	24 SEMINAR EXPENSE		BRAVO HOLDING COMPANY	100.00%	741		741	16
17	V	32 INTEREST		BRAVO HOLDING COMPANY	100.00%	(33,110)		(33,110)	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		\$			\$ (18,019)	\$ *	(18,019)	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%	\$ 34,876	\$	34,876	15
16	V	15 CORPORATE RN SALARIES BENEFITS		BRAVO NURSING HOME SERVICES, INC.	100.00%	2,421		2,421	16
17	V	17 ADMINISTRATIVE SALARIES		BRAVO NURSING HOME SERVICES, INC.	100.00%	30,493		30,493	17
18	V	19 PROFESSIONAL FEES		BRAVO NURSING HOME SERVICES, INC.	100.00%	347		347	18
19	V	20 DUES & SUBSCRIPTIONS		BRAVO NURSING HOME SERVICES, INC.	100.00%	4		4	19
20	V	21 OFFICE EXPENSES		BRAVO NURSING HOME SERVICES, INC.	100.00%	815		815	20
21	V	24 SEMINAR & LODGING EXPENSE		BRAVO NURSING HOME SERVICES, INC.	100.00%	115		115	21
22	V	25 AUTO EXPENSE		BRAVO NURSING HOME SERVICES, INC.	100.00%	2,849		2,849	22
23	V	27 ADMINISTRATIVE & OFFICE BENEFITS		BRAVO NURSING HOME SERVICES, INC.	100.00%	3,296		3,296	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			\$ 75,215	\$ *	(62,785)	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%	\$ 1,424	\$ 1,424
16	V	20 LICENSES		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	105	105
17	V	21 LEGAL SALARIES		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	16,011	16,011
18	V	21 OFFICE EXPENSE		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	216	216
19	V	24 SEMINAR		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	224	224
20	V	25 AUTO / TRAVEL EXPENSE		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	1,552	1,552
21	V	27 EMPLOYEE BENEFITS		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	1,888	1,888
22	V						
23	V	19 PROFESSIONAL FEES	23,633	CLAIMS ADMINISTRATION SERVICES, LLC	100.00%		(23,633)
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		\$ 23,633			\$ 21,420	\$ * (2,213)

\* 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%	\$ 228	\$	228	15
16	V	6 MAINTENANCE EXPENSE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	99		99	16
17	V	20 DUES, SUBSCRIPTIONS, LICENSES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	2,780		2,780	17
18	V	21 OFFICE SALARIES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	111,929		111,929	18
19	V	21 OFFICE EXPENSES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	36,084		36,084	19
20	V	24 SEMINAR		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	137		137	20
21	V	25 TRAVEL EXPENSE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	3,393		3,393	21
22	V	26 INSURANCE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	4,096		4,096	22
23	V	27 EMPLOYEE BENEFITS		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	18,794		18,794	23
24	V	30 DEPRECIATION		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	11,147		11,147	24
25	V	32 INTEREST		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	20,203		20,203	25
26	V	34 BUILDING RENT		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	15,549		15,549	26
27	V								27
28	V								28
29	V	17 ADMINISTRATIVE FEE	250,321	MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%			(250,321)	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		\$ 257,521			\$ 224,439	\$ *	(33,082)	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%	\$ 140	\$	140	15
16	V	6 MAINTENANCE SALARY		SENIOR LIVING SERVICES, INC.	100.00%	22,100		22,100	16
17	V	6 MAINTENANCE EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	1,981		1,981	17
18	V	7 MAINTENANCE BENEFITS		SENIOR LIVING SERVICES, INC.	100.00%	3,319		3,319	18
19	V	20 LICENSES		SENIOR LIVING SERVICES, INC.	100.00%	68		68	19
20	V	21 OFFICE EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	452		452	20
21	V	25 AUTO / TRAVEL EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	2,323		2,323	21
22	V	26 INSURANCE		SENIOR LIVING SERVICES, INC.	100.00%	614		614	22
23	V	30 DEPRECIATION		SENIOR LIVING SERVICES, INC.	100.00%	400		400	23
24	V								24
25	V	6 MAINTENANCE SERVICES	46,622	SENIOR LIVING SERVICES, INC.	100.00%	247		(46,375)	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		\$ 46,622			\$ 31,644	\$ *	(14,978)	39

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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





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

# 0049270

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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Rosewood Care Center Of Rockford

# 0049270

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	\$ 30,342	\$ 14,350	1
2	24	SEMINAR EXPENSE	PATIENT DAYS	445,412	14	10,876	30,342	741	2
3	32	INTEREST	PATIENT DAYS	445,412	14	(486,047)	30,342	(33,110)	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)	\$	\$ (18,019)	25

Facility Name & ID Number Rosewood Care Center Of Rockford

# 0049270

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	\$ 30,342	\$ 34,876	1
2	15	CORPORATE RN SALARIES BI	PAT. DAYS	445,412	14	35,539	30,342	2,421	2
3	17	ADMINISTRATIVE SALARIES	PAT. DAYS	445,412	14	447,622	447,622	30,493	3
4	19	PROFESSIONAL FEES	PAT. DAYS	445,412	14	5,100	30,342	347	4
5	20	DUES & SUBSCRIPTIONS	PAT. DAYS	445,412	14	53	30,342	4	5
6	21	OFFICE EXPENSES	PAT. DAYS	445,412	14	11,963	30,342	815	6
7	24	SEMINAR & LODGING EXPEN	PAT. DAYS	445,412	14	1,683	30,342	115	7
8	25	AUTO EXPENSE	PAT. DAYS	445,412	14	41,816	30,342	2,849	8
9	27	ADMINISTRATIVE & OFFICE I	PAT. DAYS	445,412	14	48,387	30,342	3,296	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	\$ 75,215	25

Facility Name & ID Number Rosewood Care Center Of Rockford

# 0049270

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	\$ 39,920	\$ 1,424	1
2	20	LICENSES	ACTUAL FEES	439,804	14	1,155	39,920	105	2
3	21	LEGAL SALARIES	ACTUAL FEES	439,804	14	176,396	176,396	16,011	3
4	21	OFFICE EXPENSE	ACTUAL FEES	439,804	14	2,382	39,920	216	4
5	24	SEMINAR	ACTUAL FEES	439,804	14	2,470	39,920	224	5
6	25	AUTO / TRAVEL EXPENSE	ACTUAL FEES	439,804	14	17,094	39,920	1,552	6
7	27	EMPLOYEE BENEFITS	ACTUAL FEES	439,804	14	20,803	39,920	1,888	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	\$ 21,420	25

Facility Name & ID Number Rosewood Care Center Of Rockford

# 0049270

Report Period Beginning:

07/01/16

Ending: 06/30/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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	5	UTILITIES	PAT. DAYS	445,412	14	\$ 3,350	\$ 30,342	\$ 228	1
2	6	MAINTENANCE EXPENSE	PAT. DAYS	445,412	14	1,452	30,342	99	2
3	20	DUES, SUBSCRIPTIONS, LICEN	PAT. DAYS	445,412	14	40,807	30,342	2,780	3
4	21	OFFICE SALARIES	PAT. DAYS	445,412	14	1,643,080	1,643,080	111,929	4
5	21	OFFICE EXPENSES	PAT. DAYS	445,412	14	529,702	30,342	36,084	5
6	24	SEMINAR	PAT. DAYS	445,412	14	2,006	30,342	137	6
7	25	TRAVEL EXPENSE	PAT. DAYS	445,412	14	49,808	30,342	3,393	7
8	26	INSURANCE	PAT. DAYS	445,412	14	60,126	30,342	4,096	8
9	27	EMPLOYEE BENEFITS	PAT. DAYS	445,412	14	275,890	30,342	18,794	9
10	30	DEPRECIATION	PAT. DAYS	445,412	14	163,642	30,342	11,147	10
11	32	INTEREST	PAT. DAYS	445,412	14	296,581	30,342	20,203	11
12	34	BUILDING RENT	PAT. DAYS	445,412	14	228,258	30,342	15,549	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	\$ 224,439	25

Facility Name & ID Number Rosewood Care Center Of Rockford

# 0049270

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	\$ 46,622	\$ 140	1
2	6	MAINTENANCE SALARY	ACTUAL FEES	931,614	14	441,618	441,618	22,100	2
3	6	MAINTENANCE EXPENSE	ACTUAL FEES	931,614	14	39,580	46,622	1,981	3
4	7	MAINTENANCE BENEFITS	ACTUAL FEES	931,614	14	66,326	46,622	3,319	4
5	20	LICENSES	ACTUAL FEES	931,614	14	1,361	46,622	68	5
6	21	OFFICE EXPENSE	ACTUAL FEES	931,614	14	9,024	46,622	452	6
7	25	AUTO / TRAVEL EXPENSE	ACTUAL FEES	931,614	14	46,424	46,622	2,323	7
8	26	INSURANCE	ACTUAL FEES	931,614	14	12,265	46,622	614	8
9	30	DEPRECIATION	ACTUAL FEES	931,614	14	8,001	46,622	400	9
10									10
11	6	MAINTENANCE SERVICES	DIRECT ALLOCATION		14	4,421		247	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	\$ 31,644	25

Facility Name & ID Number Rosewood Care Center Of Rockford

# 0049270

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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Rosewood Care Center Of Rockford

# 0049270

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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Rosewood Care Center Of Rockford

# 0049270 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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Rosewood Care Center Of Rockford

# 0049270

Report Period Beginning:

07/01/16

Ending: 06/30/17

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

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

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

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

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

Facility Name & ID Number

Rosewood Care Center Of Rockford

# 0049270

Report Period Beginning:

07/01/16

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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Berkadia		X	Mortgage	\$73,916.21	11/1/04	\$ 4,941,300	\$ 9,553,252	12/1/39	0.0470	\$ 442,839	1								
2												2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	Bravo Holding		X	Note Payable				2,928,327			167,684	6								
7	MidCap		X	Line of Credit							96,596	7								
8												8								
9	TOTAL Facility Related				\$73,916.21		\$ 4,941,300	\$ 12,481,579			\$ 707,120	9								
<b>B. Non-Facility Related*</b>																				
10	Interest Income		X								(78)	10								
11	Interest Income-Bldg Co		X								(14)	11								
12	Allocated from Bravo Holding Co	X									(33,110)	12								
13	See Supplemental Schedule										20,203	13								
14	TOTAL Non-Facility Related						\$	\$			\$ (12,999)	14								
15	TOTALS (line 9+line14)						\$ 4,941,300	\$ 12,481,579			\$ 694,121	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ 48,306      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.		\$	<b>125,691</b>	<b>1</b>
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.)		\$	<b>123,753</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(1,938)</b>	<b>3</b>
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>128,741</b>	<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>126,803</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	<b>2012</b>	<b>118,352</b>	<b>8</b>
	<b>2013</b>	<b>121,115</b>	<b>9</b>
	<b>2014</b>	<b>121,982</b>	<b>10</b>
	<b>2015</b>	<b>124,529</b>	<b>11</b>
	<b>2016</b>	<b>122,979</b>	<b>12</b>

**Accrual based on PY tax bill.**

**RE Taxes paid on Line 2 are the second installment of the 2015 tax bill and the first installment of the 2016 tax bill.**

**Beginning Accrual Adjusted**

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

**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 Rockford

# 0049270 Report Period Beginning:

07/01/16 Ending:

06/30/17

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 41,042 B. General Construction Type: Exterior Stucco Frame Wood Number of Stories 1

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

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

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

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

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO

If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_

3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs:

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

**XI. OWNERSHIP COSTS:**

A. Land.

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

Facility Name & ID Number Rosewood Care Center Of Rockford

# 0049270

Report Period Beginning:

07/01/16

Ending:

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**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	120		2013	1996	\$ 2,690,005	\$ 164,808	40	\$ 67,250	\$ (97,558)	\$ 235,375	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Rosewood Care Center Of Rockford

# 0049270

Report Period Beginning:

07/01/16

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		52,669			2,424	2,424	4,134	67
68		196		39	39		39	68
69			10,311			(10,311)		69
70		\$ 2,742,870	\$ 175,158		\$ 69,713	\$ (105,445)	\$ 239,548	70

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

Facility Name & ID Number Rosewood Care Center Of Rockford

# 0049270

Report Period Beginning:

07/01/16

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		\$ 2,742,870	\$ 175,158		\$ 69,713	\$ (105,445)	\$ 239,548	1
2	2015	2,940		20	147	147	294	2
3	2016	3,363		20	168	168	336	3
4	2017	2,890		20	145	145	145	4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 2,752,063	\$ 175,158		\$ 70,173	\$ (104,985)	\$ 240,323	34

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

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

# **0049270**

Report Period Beginning:

**07/01/16**

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		\$ 2,752,063	\$ 175,158		\$ 70,173	\$ (104,985)	\$ 240,323	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		\$ 2,752,063	\$ 175,158		\$ 70,173	\$ (104,985)	\$ 240,323	34

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

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

# **0049270**

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**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 2,752,063	\$ 175,158		\$ 70,173	\$ (104,985)	\$ 240,323	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		\$ 2,752,063	\$ 175,158		\$ 70,173	\$ (104,985)	\$ 240,323	34

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

Facility Name & ID Number Rosewood Care Center Of Rockford

# 0049270

Report Period Beginning:

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**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$ 2,752,063	\$ 175,158		\$ 70,173	\$ (104,985)	\$ 240,323
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
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18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34		\$ 2,752,063	\$ 175,158		\$ 70,173	\$ (104,985)	\$ 240,323

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

Facility Name & ID Number Rosewood Care Center Of Rockford

# 0049270

Report Period Beginning:

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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	<b>Building Company</b>		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9	<b>Doors</b>	2014	4,774		40	119	119	318	9
10	<b>Doors</b>	2015	8,790		40	220	220	525	10
11	<b>Repair Damaged Roof from Hail Storm</b>	2015	9,520		40	238	238	595	11
12	<b>Seal Coating</b>	2015	4,557		25	182	182	455	12
13	<b>Install (2) Fire Dampers in Mechanical Room</b>	2015	3,275		10	328	328	738	13
14	<b>Replace Backflow Preventor</b>	2016	4,993		10	499	499	665	14
15	<b>Fire Alarm Control Panel</b>	2016	16,760		20	838	838	838	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 52,669	\$		\$ 2,424	\$ 2,424	\$ 4,134	34

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

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

# **0049270**

Report Period Beginning:

**07/01/16**

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		\$ 52,669	\$		\$ 2,424	\$	\$ 4,134	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)	\$ 52,669	\$		\$ 2,424	\$	\$ 4,134	34

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

Facility Name & ID Number Rosewood Care Center Of Rockford

# 0049270

Report Period Beginning:

07/01/16

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									9
10	Allocated from Senior Living Services	2017	196	39	20	39		39	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)		\$ 196	\$ 39		\$ 39	\$	\$ 39	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		\$ 196	\$ 39		\$ 39		\$ 39	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	<b>TOTAL (lines 1 thru 33)</b>	\$ 196	\$ 39		\$ 39		\$ 39	34

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

Facility Name & ID Number Rosewood Care Center Of Rockford

# 0049270

Report Period Beginning:

07/01/16

Ending:

06/30/17

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 73,566	\$ 2,508	\$ 13,731	\$ 11,223	10	\$ 58,595	71
72	Current Year Purchases	3,207		321	321	10	321	72
73	Fully Depreciated Assets	16,891	89	89		10	16,891	73
74								74
75	TOTALS	\$ 93,664	\$ 2,597	\$ 14,141	\$ 11,544		\$ 75,807	75

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

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from MAS	2017	\$ 45,713	\$ 8,550	\$ 8,550	\$	5	\$ 37,628	76
77		Allocated from Senior Living Ser	2017	7,491	361	361		5	7,370	77
78										78
79										79
80	TOTALS			\$ 53,204	\$ 8,911	\$ 8,911	\$		\$ 44,998	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)	\$ 3,161,405	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 186,666	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 93,225	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (93,441)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 361,128	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				3,981			5
6	Allocated from MAS				15,549			6
7	TOTAL				\$ 19,530			7

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES  NO

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

(Attach a schedule detailing the breakdown of movable equipment)

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

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ /2018 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2019 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2020 \$ \_\_\_\_\_

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

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

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

**A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	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)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5	6	7	8		
			Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)						Total Cost (Col. 3 + 5 + 6)
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	406,162	\$			\$	406,162	1	
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				42,716					42,716	2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist	39 - 03	hrs				404,995					404,995	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						331,907			331,907	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10	
11	Academic Education		hrs										11	
12	Other (specify):												12	
13	Other (specify):						30,406		21,870			52,276	13	
14	TOTAL			\$		\$	884,279	\$	353,777	\$		1,238,056	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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,320	\$ 1,320	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	3,007,983	3,007,983	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	56,015	59,439	6
7	Other Prepaid Expenses		179,303	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <b>See Attached Schedule</b>	7,888	7,888	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,073,206	\$ 3,255,933	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		985,300	13
14	Buildings, at Historical Cost		4,053,455	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	51,556	671,140	16
17	Accumulated Depreciation (book methods)	(42,426)	(3,232,801)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 9,130	\$ 2,477,094	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,082,336	\$ 5,733,027	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 2,944,885	\$ 2,983,804	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,928,327	2,928,327	29
30	Accrued Salaries Payable	136,597	136,597	30
31	Accrued Taxes Payable (excluding real estate taxes)	216,520	216,520	31
32	Accrued Real Estate Taxes(Sch.IX-B)		128,741	32
33	Accrued Interest Payable		926,104	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	3,529	3,529	35
	<b>Other Current Liabilities(specify):</b>			
36	<b>See Attached Schedule</b>	2,274,013	551,889	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 8,503,871	\$ 7,875,511	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,553,252	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 9,553,252	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 8,503,871	\$ 17,428,763	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (5,421,535)	\$ (11,695,736)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,082,336	\$ 5,733,027	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(5,030,257)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Rounding</b>	<b>3</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(5,030,254)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(391,281)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(391,281)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(5,421,535)</b>	<b>24</b> *

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

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

# 0049270

Report Period Beginning: 07/01/16

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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 7,902,494	1
2	Discounts and Allowances for all Levels	(3,101,325)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,801,169	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,676,151	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 2,676,151	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	900	13
14	Non-Patient Meals	4,400	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	404,390	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	63,016	19
20	Radiology and X-Ray	8,384	20
21	Other Medical Services	123,131	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 604,221	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	78	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 78	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>See Supplemental Schedule</b>	11,067	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 11,067	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 8,092,686	30

2

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,286,120	31
32	Health Care	2,917,675	32
33	General Administration	1,479,564	33
<b>B. Capital Expense</b>			
34	Ownership	1,247,838	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,343,840	35
36	Provider Participation Fee	208,930	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 8,483,967	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(391,281)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (391,281)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,917,152	44
45	Private Pay - Net Inpatient Revenue	1,693,414	45
46	Medicare - Net Inpatient Revenue	986,989	46
47	Other-(specify) <u>Managed Care</u>	203,614	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 4,801,169	49

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Rosewood Care Center Of Rockford

# 0049270

Report Period Beginning:

07/01/16

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	2,045	2,310	\$ 88,884	\$ 38.48	1
2	Assistant Director of Nursing	2,943	3,270	86,296	26.39	2
3	Registered Nurses	11,848	12,604	358,234	28.42	3
4	Licensed Practical Nurses	20,107	21,619	524,501	24.26	4
5	CNAs & Orderlies	70,687	74,920	795,267	10.61	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,066	7,681	103,766	13.51	8
9	Activity Director	2,142	2,308	30,083	13.03	9
10	Activity Assistants	3,303	3,513	30,004	8.54	10
11	Social Service Workers	4,164	4,475	62,720	14.02	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	2,577	2,876	39,979	13.90	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,419	2,774	101,818	36.70	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,065	9,993	126,052	12.61	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,369	4,659	71,325	15.31	31
32	Other Health Care(specify)					32
33	Other(specify)	4,334	4,730	103,551	21.89	33
34	TOTAL (lines 1 - 33)	147,069	157,732	\$ 2,522,480 *	\$ 15.99	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	7,700	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,875	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) <u>Outsourced Dietary</u>	Monthly	382,992	01-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 403,767		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	4,211	\$ 172,636	10-03	50
51	Licensed Practical Nurses	6,026	204,882	10-03	51
52	Certified Nurse Assistants/Aides	5,907	124,039	10-03	52
53	TOTAL (lines 50 - 52)	16,143	\$ 501,557		53



Facility Name & ID Number Rosewood Care Center Of Rockford# 0049270Report 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 \$6,670
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 49,411 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. \$ 208,930  
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. \$ 4,400
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 100% LN 14  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. **Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees