

Facility Name & ID Number Rosewood Care Center Of St. Charles

0049320 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	109	Skilled (SNF)	109	39,785	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	109	TOTALS	109	39,785	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	14,312	6,892	6,036	27,240	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,312	6,892	6,036	27,240	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.47%

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 49 and days of care provided 4,430

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 St. Charles # 0049320 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		4,992	394,907	399,899		399,899		399,899		1
2	Food Purchase		182,893		182,893		182,893	(7,818)	175,075		2
3	Housekeeping		12,756	172,289	185,045		185,045		185,045		3
4	Laundry			114,860	114,860		114,860		114,860		4
5	Heat and Other Utilities			190,266	190,266		190,266	(10,755)	179,511		5
6	Maintenance	40,935	9,226	234,192	284,353		284,353	(43,739)	240,614		6
7	Other (specify):*							5,669	5,669		7
8	TOTAL General Services	40,935	209,867	1,106,514	1,357,316		1,357,316	(56,644)	1,300,672		8
	B. Health Care and Programs										
9	Medical Director			5,538	5,538		5,538		5,538		9
10	Nursing and Medical Records	1,753,821	230,047	961,492	2,945,360		2,945,360	31,310	2,976,670		10
10a	Therapy	101,519	1,366		102,885		102,885		102,885		10a
11	Activities	69,224	4,200	2,496	75,920		75,920		75,920		11
12	Social Services	50,658		2,400	53,058		53,058		53,058		12
13	CNA Training										13
14	Program Transportation			7,313	7,313		7,313		7,313		14
15	Other (specify):*							2,173	2,173		15
16	TOTAL Health Care and Programs	1,975,222	235,613	979,239	3,190,074		3,190,074	33,484	3,223,558		16
	C. General Administration										
17	Administrative	99,063		346,960	446,023		446,023	(319,585)	126,438		17
18	Directors Fees										18
19	Professional Services			170,950	170,950		170,950	(1,552)	169,398		19
20	Dues, Fees, Subscriptions & Promotions			15,337	15,337		15,337	(2)	15,335		20
21	Clerical & General Office Expenses	112,833	21,567	333,410	467,810		467,810	(158,219)	309,591		21
22	Employee Benefits & Payroll Taxes			299,182	299,182		299,182		299,182		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,963	2,963		2,963	1,024	3,987		24
25	Other Admin. Staff Transportation			4,542	4,542		4,542	10,494	15,036		25
26	Insurance-Prop.Liab.Malpractice			73,393	73,393		73,393	13,734	87,127		26
27	Other (specify):*							20,954	20,954		27
28	TOTAL General Administration	211,896	21,567	1,246,737	1,480,200		1,480,200	(433,152)	1,047,048		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,228,053	467,047	3,332,490	6,027,590		6,027,590	(456,312)	5,571,278		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 St. Charles

#0049320

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			13,650	13,650		13,650	122,750	136,400			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			293,670	293,670		293,670	496,018	789,688			32
33	Real Estate Taxes							192,267	192,267			33
34	Rent-Facility & Grounds			1,094,996	1,094,996		1,094,996	(1,076,041)	18,955			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			18,366	18,366		18,366	37,085	55,451			36
37	TOTAL Ownership			1,420,682	1,420,682		1,420,682	(227,922)	1,192,760			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		250,224	725,115	975,339		975,339		975,339			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			199,100	199,100		199,100		199,100			42
43	Other (specify):*	70,935		1,347	72,282		72,282	(72,282)				43
44	TOTAL Special Cost Centers	70,935	250,224	925,562	1,246,721		1,246,721	(72,282)	1,174,439			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,298,988	717,271	5,678,734	8,694,993		8,694,993	(756,516)	7,938,477			45

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

Rosewood Care Center Of St. Charles

ID# 0049320

Report Period Beginning: 07/01/16

Ending: 06/30/17

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Bank Charges	\$ (4,744)	21	1
2	Vendor Late Charges	(40,580)	21	2
3	Marketing Salary	(70,935)	43	3
4	Midcap Line of Credit Fees	(18,366)	36	4
5	Marketing Expense	(1,347)	43	5
6	Vending Income	(188)	02	6
7	Miscellaneous Income	(2,014)	21	7
8	PAC Dues	(2,263)	20	8
9	Non Allowable Legal	(1,830)	19	9
10	Capitalized R&M	(5,975)	06	10
11	Bldg Co - Audit Fees	(9,720)	19	11
12	Bldg Co - Prof Fees	(9,030)	19	12
13	Bldg Co - Bank Charges	(15,271)	21	13
14	Bldg Co - Amortization	(5,071)	36	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	(187,334)		49

Rosewood Care Center Of St. Charles

ID# 0049320
 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	Total		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Center Of St. Charles# 0049320

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	(7,818)											(7,818)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(11,198)					205	238					(10,755)	5
6	Maintenance	(5,975)					89	(37,853)					(43,739)	6
7	Other (specify):*							5,669					5,669	7
8	TOTAL General Services	(24,991)					294	(31,946)					(56,644)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				31,310								31,310	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				2,173								2,173	15
16	TOTAL Health Care and Programs				33,484								33,484	16
	C. General Administration													
17	Administrative				(110,625)		(208,960)						(319,585)	17
18	Directors Fees													18
19	Professional Services	(20,580)	18,750	12,883	312	(12,918)							(1,552)	19
20	Fees, Subscriptions & Promotions	(2,680)			3	62	2,496	116					(2)	20
21	Clerical & General Office Expenses	(317,519)	22,471		732	9,646	125,680	771					(158,219)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			665	103	133	123						1,024	24
25	Other Admin. Staff Transportation				2,557	922	3,046	3,968					10,494	25
26	Insurance-Prop.Liab.Malpractice		9,009				3,677	1,048					13,734	26
27	Other (specify):*				2,959	1,122	16,873						20,954	27
28	TOTAL General Administration	(340,779)	50,230	13,548	(103,959)	(1,031)	(57,065)	5,904					(433,152)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(365,770)	50,230	13,548	(70,475)	(1,031)	(56,772)	(26,043)					(456,312)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Center Of St. Charles # 0049320 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	(125,800)	237,858				10,008	684					122,750	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(44)	507,649	(29,725)			18,138						496,018	32
33	Real Estate Taxes		192,267										192,267	33
34	Rent-Facility & Grounds		(1,090,001)				13,960						(1,076,041)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*	(23,437)	60,522										37,085	36
37	TOTAL Ownership	(149,281)	(91,705)	(29,725)			42,105	684					(227,922)	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):*	(72,282)											(72,282)	43
44	TOTAL Special Cost Centers	(72,282)											(72,282)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(587,333)	(41,475)	(16,177)	(70,475)	(1,031)	(14,666)	(25,359)					(756,516)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 1,090,001	St. Charles Real Estate	100.00%	\$	(1,090,001)	1
2	V	32 Interest	11	St. Charles Real Estate	100.00%	507,660	507,649	2
3	V	19 Audit Fees		St. Charles Real Estate	100.00%	9,720	9,720	3
4	V	19 Professional Fees		St. Charles Real Estate	100.00%	9,030	9,030	4
5	V	21 Bank Charges		St. Charles Real Estate	100.00%	15,271	15,271	5
6	V	33 Real Estate Tax		St. Charles Real Estate	100.00%	192,267	192,267	6
7	V	30 Depreciation		St. Charles Real Estate	100.00%	237,858	237,858	7
8	V	36 Amortization Loan Fee		St. Charles Real Estate	100.00%	5,071	5,071	8
9	V	21 Base Admin Fee (Page 6D)		St. Charles Real Estate	100.00%	7,200	7,200	9
10	V	26 Insurance Expense - Property		St. Charles Real Estate	100.00%	9,009	9,009	10
11	V	36 Interest Exp-HUD MIP		St. Charles Real Estate	100.00%	55,451	55,451	11
12	V							12
13	V							13
14	Total		\$ 1,090,012			\$ 1,048,537	\$ * (41,475)	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%	\$ 12,883	\$ 12,883
16	V	24 SEMINAR EXPENSE		BRAVO HOLDING COMPANY	100.00%	665	665
17	V	32 INTEREST		BRAVO HOLDING COMPANY	100.00%	(29,725)	(29,725)
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
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		\$			\$ (16,177)	\$ * (16,177)

* 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%	\$ 31,310	\$ 31,310
16	V	15 CORPORATE RN SALARIES BENEFITS		BRAVO NURSING HOME SERVICES, INC.	100.00%	2,173	2,173
17	V	17 ADMINISTRATIVE SALARIES		BRAVO NURSING HOME SERVICES, INC.	100.00%	27,375	27,375
18	V	19 PROFESSIONAL FEES		BRAVO NURSING HOME SERVICES, INC.	100.00%	312	312
19	V	20 DUES & SUBSCRIPTIONS		BRAVO NURSING HOME SERVICES, INC.	100.00%	3	3
20	V	21 OFFICE EXPENSES		BRAVO NURSING HOME SERVICES, INC.	100.00%	732	732
21	V	24 SEMINAR & LODGING EXPENSE		BRAVO NURSING HOME SERVICES, INC.	100.00%	103	103
22	V	25 AUTO EXPENSE		BRAVO NURSING HOME SERVICES, INC.	100.00%	2,557	2,557
23	V	27 ADMINISTRATIVE & OFFICE BENEFITS		BRAVO NURSING HOME SERVICES, INC.	100.00%	2,959	2,959
24	V						
25	V						
26	V	17 ADMINISTRATIVE FEE	138,000	BRAVO NURSING HOME SERVICES, INC.	100.00%		(138,000)
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		\$ 138,000			\$ 67,525	\$ * (70,475)

* 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%	\$ 846	\$	846	15
16	V	20 LICENSES		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	62		62	16
17	V	21 LEGAL SALARIES		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	9,518		9,518	17
18	V	21 OFFICE EXPENSE		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	129		129	18
19	V	24 SEMINAR		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	133		133	19
20	V	25 AUTO / TRAVEL EXPENSE		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	922		922	20
21	V	27 EMPLOYEE BENEFITS		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	1,122		1,122	21
22	V								22
23	V	19 PROFESSIONAL FEES	13,764	CLAIMS ADMINISTRATION SERVICES, LLC	100.00%			(13,764)	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		\$ 13,764			\$ 12,733	\$ *	(1,031)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 UTILITIES	\$	MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	\$ 205	\$	205	15
16	V	6 MAINTENANCE EXPENSE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	89		89	16
17	V	20 DUES, SUBSCRIPTIONS, LICENSES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	2,496		2,496	17
18	V	21 OFFICE SALARIES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	100,486		100,486	18
19	V	21 OFFICE EXPENSES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	32,395		32,395	19
20	V	24 SEMINAR		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	123		123	20
21	V	25 TRAVEL EXPENSE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	3,046		3,046	21
22	V	26 INSURANCE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	3,677		3,677	22
23	V	27 EMPLOYEE BENEFITS		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	16,873		16,873	23
24	V	30 DEPRECIATION		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	10,008		10,008	24
25	V	32 INTEREST		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	18,138		18,138	25
26	V	34 BUILDING RENT		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	13,960		13,960	26
27	V								27
28	V								28
29	V	17 ADMINISTRATIVE FEE	208,960	MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%			(208,960)	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		\$ 216,160			\$ 201,494	\$ *	(14,666)	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%	\$ 238	\$	238	15
16	V	6 MAINTENANCE SALARY		SENIOR LIVING SERVICES, INC.	100.00%	37,744		37,744	16
17	V	6 MAINTENANCE EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	3,383		3,383	17
18	V	7 MAINTENANCE BENEFITS		SENIOR LIVING SERVICES, INC.	100.00%	5,669		5,669	18
19	V	20 LICENSES		SENIOR LIVING SERVICES, INC.	100.00%	116		116	19
20	V	21 OFFICE EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	771		771	20
21	V	25 AUTO / TRAVEL EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	3,968		3,968	21
22	V	26 INSURANCE		SENIOR LIVING SERVICES, INC.	100.00%	1,048		1,048	22
23	V	30 DEPRECIATION		SENIOR LIVING SERVICES, INC.	100.00%	684		684	23
24	V								24
25	V	6 MAINTENANCE SERVICES	79,623	SENIOR LIVING SERVICES, INC.	100.00%	643		(78,980)	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		\$ 79,623			\$ 54,264	\$ *	(25,359)	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		\$			\$	\$	bintz	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 St. Charles # 0049320 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 St. Charles

0049320

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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	TOTALS				\$	\$		\$	25

Facility Name & ID Number Rosewood Care Center Of St. Charles

0049320

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	\$ 27,240	\$ 12,883	1
2	24	SEMINAR EXPENSE	PATIENT DAYS	445,412	14	10,876	27,240	665	2
3	32	INTEREST	PATIENT DAYS	445,412	14	(486,047)	27,240	(29,725)	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)	\$	\$ (16,177)	25

Facility Name & ID Number Rosewood Care Center Of St. Charles

0049320

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	\$ 27,240	\$ 31,310	1
2	15	CORPORATE RN SALARIES BI	PAT. DAYS	445,412	14	35,539	27,240	2,173	2
3	17	ADMINISTRATIVE SALARIES	PAT. DAYS	445,412	14	447,622	447,622	27,375	3
4	19	PROFESSIONAL FEES	PAT. DAYS	445,412	14	5,100	27,240	312	4
5	20	DUES & SUBSCRIPTIONS	PAT. DAYS	445,412	14	53	27,240	3	5
6	21	OFFICE EXPENSES	PAT. DAYS	445,412	14	11,963	27,240	732	6
7	24	SEMINAR & LODGING EXPEN	PAT. DAYS	445,412	14	1,683	27,240	103	7
8	25	AUTO EXPENSE	PAT. DAYS	445,412	14	41,816	27,240	2,557	8
9	27	ADMINISTRATIVE & OFFICE I	PAT. DAYS	445,412	14	48,387	27,240	2,959	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	\$ 67,525	25

Facility Name & ID Number Rosewood Care Center Of St. Charles

0049320

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	\$ 23,730	\$ 846	1
2	20	LICENSES	ACTUAL FEES	439,804	14	1,155	23,730	62	2
3	21	LEGAL SALARIES	ACTUAL FEES	439,804	14	176,396	176,396	9,518	3
4	21	OFFICE EXPENSE	ACTUAL FEES	439,804	14	2,382	23,730	129	4
5	24	SEMINAR	ACTUAL FEES	439,804	14	2,470	23,730	133	5
6	25	AUTO / TRAVEL EXPENSE	ACTUAL FEES	439,804	14	17,094	23,730	922	6
7	27	EMPLOYEE BENEFITS	ACTUAL FEES	439,804	14	20,803	23,730	1,122	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	\$ 12,733	25

Facility Name & ID Number Rosewood Care Center Of St. Charles

0049320

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	\$ 27,240	\$ 205	1
2	6	MAINTENANCE EXPENSE	PAT. DAYS	445,412	14	1,452	27,240	89	2
3	20	DUES, SUBSCRIPTIONS, LICEN	PAT. DAYS	445,412	14	40,807	27,240	2,496	3
4	21	OFFICE SALARIES	PAT. DAYS	445,412	14	1,643,080	1,643,080	100,486	4
5	21	OFFICE EXPENSES	PAT. DAYS	445,412	14	529,702	27,240	32,395	5
6	24	SEMINAR	PAT. DAYS	445,412	14	2,006	27,240	123	6
7	25	TRAVEL EXPENSE	PAT. DAYS	445,412	14	49,808	27,240	3,046	7
8	26	INSURANCE	PAT. DAYS	445,412	14	60,126	27,240	3,677	8
9	27	EMPLOYEE BENEFITS	PAT. DAYS	445,412	14	275,890	27,240	16,873	9
10	30	DEPRECIATION	PAT. DAYS	445,412	14	163,642	27,240	10,008	10
11	32	INTEREST	PAT. DAYS	445,412	14	296,581	27,240	18,138	11
12	34	BUILDING RENT	PAT. DAYS	445,412	14	228,258	27,240	13,960	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	\$ 201,494	25

Facility Name & ID Number Rosewood Care Center Of St. Charles

0049320

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	\$ 79,623	\$ 238	1
2	6	MAINTENANCE SALARY	ACTUAL FEES	931,614	14	441,618	441,618	37,744	2
3	6	MAINTENANCE EXPENSE	ACTUAL FEES	931,614	14	39,580	79,623	3,383	3
4	7	MAINTENANCE BENEFITS	ACTUAL FEES	931,614	14	66,326	79,623	5,669	4
5	20	LICENSES	ACTUAL FEES	931,614	14	1,361	79,623	116	5
6	21	OFFICE EXPENSE	ACTUAL FEES	931,614	14	9,024	79,623	771	6
7	25	AUTO / TRAVEL EXPENSE	ACTUAL FEES	931,614	14	46,424	79,623	3,968	7
8	26	INSURANCE	ACTUAL FEES	931,614	14	12,265	79,623	1,048	8
9	30	DEPRECIATION	ACTUAL FEES	931,614	14	8,001	79,623	684	9
10									10
11	6	MAINTENANCE SERVICES	DIRECT ALLOCATION		14	4,421		643	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	\$ 54,264	25

Facility Name & ID Number Rosewood Care Center Of St. Charles

0049320

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 St. Charles

0049320

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 St. Charles

0049320

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 St. Charles

0049320

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 St. Charles # 0049320 Report Period Beginning: 07/01/16 Ending: 06/30/17

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Berkadia		X	Mortgage Payable	82,450.45	11/1/04	\$ 9,101,649	\$ 11,010,885	12/1/39	0.0469	\$ 507,660	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	Midcap		X	Line of Credit							108,549	6								
7	Bravo Holding		X	Note Payable				3,285,944			185,121	7								
8												8								
9	TOTAL Facility Related				\$82,450.45		\$ 9,101,649	\$ 14,296,829			\$ 801,330	9								
B. Non-Facility Related*																				
10	Interest Income		X								(44)	10								
11	Interest Income-Bldg Co		X								(11)	11								
12	Allocated from Bravo Holding Co	X									(29,725)	12								
13	See Supplemental Schedule										18,138	13								
14	TOTAL Non-Facility Related						\$	\$			\$ (11,642)	14								
15	TOTALS (line 9+line14)						\$ 9,101,649	\$ 14,296,829			\$ 789,688	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 55,451 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.		\$	147,807	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.)		\$	180,039	2
3. Under or (over) accrual (line 2 minus line 1).		\$	32,232	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	160,036	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.		\$	192,268	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2012	110,066	8
	2013	141,193	9
	2014	148,206	10
	2015	145,188	11
	2016	214,889	12

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.

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 St. Charles

0049320

Report Period Beginning:

07/01/16

Ending:

06/30/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,252 B. General Construction Type: Exterior Brick Veneer Frame Steel 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.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: Facility, 8.35 Acres, 2013, \$ 1,577,420, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, (blank), (blank), \$ 1,577,420, 3.

Facility Name & ID Number Rosewood Care Center Of St. Charles

0049320

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	109		2013	1999	\$ 4,302,741	\$ 237,858	40	\$ 107,569	\$ (130,289)	\$ 376,491	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		2009		4,206		20	150	150	4,206	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		43,580			1,631	1,631	4,410	67
68		335	67		67		67	68
69			13,650			(13,650)		69
70		\$ 4,350,862	\$ 251,575		\$ 109,417	\$ (142,158)	\$ 385,174	70

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

Facility Name & ID Number Rosewood Care Center Of St. Charles

0049320

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	Totals from Page 12A, Carried Forward		\$ 4,350,862	\$ 251,575		\$ 109,417	\$ (142,158)	\$ 385,174	1
2	Repair Broken Sewer In Dining Room Area	2015	8,192		20	410	410	819	2
3	Thermostat Valve & Compressor	2015	3,328		20	166	166	333	3
4	Pipe Repair	2016	12,619		20	631	631	1,262	4
5	Install 56 Ft Sewer Pipe Liner	2016	5,600		20	280	280	560	5
6	Plumbing Repair	2016	4,500		20	225	225	450	6
7	Replace Spray Pump For Cooling Tower	2016	3,601		20	180	180	360	7
8	Room 518 Door Closer	2016	3,323		20	166	166	166	8
9	Metal Doors 1 & 11	2017	2,652		20	133	133	133	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)		\$ 4,394,677	\$ 251,575		\$ 111,607	\$ (139,968)	\$ 389,256	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		\$ 4,394,677	\$ 251,575		\$ 111,607	\$ (139,968)	\$ 389,256	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		\$ 4,394,677	\$ 251,575		\$ 111,607	\$ (139,968)	\$ 389,256	34

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

Facility Name & ID Number Rosewood Care Center Of St. Charles

0049320

Report Period Beginning:

07/01/16

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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		\$ 4,394,677	\$ 251,575		\$ 111,607	\$ (139,968)	\$ 389,256	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)	\$ 4,394,677	\$ 251,575		\$ 111,607	\$ (139,968)	\$ 389,256	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		\$ 4,394,677	\$ 251,575		\$ 111,607	\$ (139,968)	\$ 389,256	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		\$ 4,394,677	\$ 251,575		\$ 111,607	\$ (139,968)	\$ 389,256	34

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

Facility Name & ID Number Rosewood Care Center Of St. Charles

0049320

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	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	Window Sills	2014	8,338		40	208	208	728	9
10	Doors	2014	4,190		40	105	105	332	10
11	Cooling Tower	2014	3,717		10	372	372	1,178	11
12	Concrete Sidewalk	2014	6,000		25	240	240	760	12
13	Seal Coating	2014	6,303		25	252	252	693	13
14	Replace Shower Wall	2015	5,079		40	127	127	296	14
15	Foundation Repair	2016	6,825		40	171	171	267	15
16	Copper Boiler	2017	3,128		20	156	156	156	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)		\$ 43,580	\$		\$ 1,631	\$ 1,631	\$ 4,410	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		\$ 43,580	\$		\$ 1,631	\$	\$ 4,410	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)	\$ 43,580	\$		\$ 1,631	\$	\$ 4,410	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Senior Living Services	2017	335	67	20	67		67	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)		\$ 335	\$ 67		\$ 67	\$	\$ 67	34

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

Facility Name & ID Number Rosewood Care Center Of St. Charles

0049320

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		\$ 335	\$ 67		\$ 67		\$ 67	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)	\$ 335	\$ 67		\$ 67		\$ 67	34

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

Facility Name & ID Number Rosewood Care Center Of St. Charles

0049320

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	\$ 85,750	\$ 2,252	\$ 16,420	\$ 14,168	10	\$ 65,121	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	15,164	80	80		10	15,164	73
74								74
75	TOTALS	\$ 100,914	\$ 2,332	\$ 16,500	\$ 14,168		\$ 80,285	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	\$ 41,040	\$ 7,676	\$ 7,676	\$	5	\$ 33,781	76
77		Allocated from Senior Living Ser	2017	12,793	617	617		5	12,587	77
78										78
79										79
80	TOTALS			\$ 53,833	\$ 8,293	\$ 8,293	\$		\$ 46,368	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,126,844	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 262,200	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 136,400	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (125,800)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 515,909	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Rosewood Care Center Of St. Charles

0049320

Report Period Beginning: 07/01/16

Ending: 06/30/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Off-Site Storage				4,995			5
6	Allocated from MAS				13,960			6
7	TOTAL				\$ 18,955			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.

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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 270,401	\$		\$ 270,401	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			111,856			111,856	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			302,838			302,838	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				241,800		241,800	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					40,020	8,424		48,444	13
14	TOTAL			\$		\$ 725,115	\$ 250,224		\$ 975,339	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	\$ 1,064	\$ 1,064	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,770,578	2,770,578	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	63,190	66,550	6
7	Other Prepaid Expenses	4,447	4,447	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	19,082	2,442,631	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,858,361	\$ 5,285,270	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,577,420	13
14	Buildings, at Historical Cost		5,878,287	14
15	Leasehold Improvements, at Historical Cost	4,206	1,211,102	15
16	Equipment, at Historical Cost	67,500	843,137	16
17	Accumulated Depreciation (book methods)	(60,353)	(4,243,340)	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): <u>See Attached Schedule</u>		193,343	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 11,353	\$ 5,459,949	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,869,714	\$ 10,745,219	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,926,703	\$ 3,012,995	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	3,285,944	3,285,944	29
30	Accrued Salaries Payable	140,251	140,251	30
31	Accrued Taxes Payable (excluding real estate taxes)	178,925	178,925	31
32	Accrued Real Estate Taxes(Sch.IX-B)		160,036	32
33	Accrued Interest Payable		1,069,392	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	12,184	12,184	35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	2,476,896	2,908,366	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 9,020,903	\$ 10,768,093	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,010,885	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)	\$	\$ 11,010,885	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 9,020,903	\$ 21,778,978	46
47	TOTAL EQUITY(page 18, line 24)	\$ (6,151,189)	\$ (11,033,759)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,869,714	\$ 10,745,219	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,795,489)	1
2	Restatements (describe):		2
3	Rounding	7	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (4,795,482)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,355,707)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,355,707)	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)	\$ (6,151,189)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Rosewood Care Center Of St. Charles

0049320

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	\$ 7,082,408	1
2	Discounts and Allowances for all Levels	(1,263,720)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,818,688	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,199,115	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,199,115	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	1,600	13
14	Non-Patient Meals	1,649	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	280,258	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	23,424	19
20	Radiology and X-Ray	6,517	20
21	Other Medical Services	271	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 313,719	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	44	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 44	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	7,720	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,720	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,339,286	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,357,316	31
32	Health Care	3,190,074	32
33	General Administration	1,480,200	33
B. Capital Expense			
34	Ownership	1,420,682	34
C. Ancillary Expense			
35	Special Cost Centers	1,047,621	35
36	Provider Participation Fee	199,100	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,694,993	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,355,707)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,355,707)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,884,938	44
45	Private Pay - Net Inpatient Revenue	2,218,389	45
46	Medicare - Net Inpatient Revenue	736,358	46
47	Other-(specify) Managed Care	979,003	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,818,688	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 St. Charles

0049320

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	1,368	1,573	\$ 61,108	\$ 38.85	1
2	Assistant Director of Nursing	2,507	2,639	81,884	31.03	2
3	Registered Nurses	22,149	23,816	746,862	31.36	3
4	Licensed Practical Nurses	6,383	7,093	180,790	25.49	4
5	CNAs & Orderlies	46,812	49,800	643,416	12.92	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,285	6,906	101,519	14.70	8
9	Activity Director	2,215	2,451	37,311	15.22	9
10	Activity Assistants	3,489	3,731	31,913	8.55	10
11	Social Service Workers	3,476	3,712	50,658	13.65	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	2,425	2,586	40,935	15.83	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,160	2,398	99,063	41.31	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,634	10,487	112,833	10.76	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,477	3,701	39,761	10.74	31
32	Other Health Care(specify)					32
33	Other(specify)	3,286	3,490	70,935	20.33	33
34	TOTAL (lines 1 - 33)	115,666	124,383	\$ 2,298,988 *	\$ 18.48	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	5,538	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,010	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	2,496	11-03	44
45	Social Service Consultant	Monthly	2,400	12-03	45
46	Other(specify) <u>Outsourced Dietary</u>	Monthly	394,907	01-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 412,351		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	5,982	\$ 316,740	10-03	50
51	Licensed Practical Nurses	5,406	264,622	10-03	51
52	Certified Nurse Assistants/Aides	14,378	373,120	10-03	52
53	TOTAL (lines 50 - 52)	25,766	\$ 954,482		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Ivy Gleeson	Administrator	0	\$ 95,140	Workers' Compensation Insurance	\$ 67,720	IDPH License Fee	\$ 3,980	
William Sekalias	Admin as of 6/27/17	0	3,923	Unemployment Compensation Insurance	20,527	Advertising: Employee Recruitment	545	
				FICA Taxes	174,518	Health Care Worker Background Check	2,655	
				Employee Health Insurance	30,244	(Indicate # of checks performed <u>265</u>)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	5,477	
				Employee Physicals & Vaccinations	956	Allocated from Bravo Nursing Home	3	
				Employee Drug Tests	269	Allocated from CAS	62	
				401K Expense	3,069	Allocated from MAS	2,496	
				Employee Relations	1,878	See Supplemental Schedule	116	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)					\$ 99,063	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 15,334
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
Volume Admin Fee - Midwest Admin Services			\$ 172,960				Out-of-State Travel	\$
Base Management Fee - Bravo Nursing Home Services			138,000					
Base Admin Fee - Midwest Admin Services			36,000				In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 346,960				Seminar Expense	2,963
							Allocated from Bravo Holding Company	665
							Allocated from Bravo Nursing Home	103
							See Supplemental Schedule	256
							Entertainment Expense	()
							(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)			\$ 170,951	TOTAL		\$	TOTAL	\$ 3,987

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Rosewood Care Center Of St. Charles# 0049320Report 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 \$6,007
- (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. \$ 52,587 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. \$ 199,100
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. \$ 1,649
- (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