FOR BHF USE

LL1

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0049270

Facility Name: Rosewood Care Center Of Rockford

Address: 1660 S. Mulford Road (Number) Rockford (City) 61108 (Zip Code)

County: Winnebago

Telephone Number: (815) 397-8700 **Fax #** (815) 397-4880

HFS ID Number:

Date of Initial License for Current Owners: 12/1/2007

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda **Telephone Number:** (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/17 to 06/30/18 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Rosewood Care Center Of Rockford # 0049270 Report Period Beginning: 07/01/17 Ending: 06/30/18

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	14,467	5,523	7,645	27,635	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,467	5,523	7,645	27,635	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.09%

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

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 [X] Date 12/01/2007 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 58 and days of care provided 4,667

Medicare Intermediary Novitas Solutions, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

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

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

Facility Name & ID Number Rosewood Care Center Of Rockford # 0049270 Report Period Beginning: 07/01/17 Ending: 06/30/18

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary			382,504	382,504		382,504		382,504			1
2	Food Purchase		199,396		199,396		199,396	(5,777)	193,619			2
3	Housekeeping		10,197	175,668	185,865		185,865		185,865			3
4	Laundry			117,112	117,112		117,112		117,112			4
5	Heat and Other Utilities			146,221	146,221		146,221	(9,887)	136,334			5
6	Maintenance	40,755	6,448	255,900	303,103		303,103	(31,659)	271,444			6
7	Other (specify):*							3,472	3,472			7
8	**TOTAL General Services**	40,755	216,041	1,077,405	1,334,201		1,334,201	(43,850)	1,290,351			8
	B. Health Care and Programs											
9	Medical Director			2,950	2,950		2,950		2,950			9
10	Nursing and Medical Records	2,105,983	284,284	48,130	2,438,397		2,438,397	28,821	2,467,218			10
10a	Therapy	91,238	2,246		93,484		93,484		93,484			10a
11	Activities	58,569	5,469	2,500	66,538		66,538		66,538			11
12	Social Services	62,082		2,500	64,582		64,582		64,582			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							2,985	2,985			15
16	**TOTAL Health Care and Programs**	2,317,872	291,999	56,080	2,665,951		2,665,951	31,806	2,697,757			16
	C. General Administration											
17	Administrative	114,212		330,029	444,241		444,241	(296,426)	147,815			17
18	Directors Fees											18
19	Professional Services			94,921	94,921		94,921	(23,190)	71,731			19
20	Dues, Fees, Subscriptions & Promotions			18,980	18,980		18,980	760	19,740			20
21	Clerical & General Office Expenses	129,518	18,088	392,946	540,552		540,552	(247,536)	293,016			21
22	Employee Benefits & Payroll Taxes			389,278	389,278		389,278		389,278			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,095	3,095		3,095	393	3,488			24
25	Other Admin. Staff Transportation			4,051	4,051		4,051	11,791	15,842			25
26	Insurance-Prop.Liab.Malpractice			96,112	96,112		96,112	12,539	108,651			26
27	Other (specify):*							25,325	25,325			27
28	**TOTAL General Administration**	243,730	18,088	1,329,412	1,591,230		1,591,230	(516,344)	1,074,886			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,602,357	526,128	2,462,897	5,591,382		5,591,382	(528,388)	5,062,994			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 Rockford #0049270 Report Period Beginning: 07/01/17 Ending: 06/30/18

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			8,752	8,752		8,752	79,691	88,443			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			243,013	243,013		243,013	369,734	612,747			32
33	Real Estate Taxes							116,434	116,434			33
34	Rent-Facility & Grounds			958,196	958,196		958,196	(938,572)	19,624			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			22,653	22,653		22,653	17,601	40,254			36
37	**TOTAL Ownership**			1,232,614	1,232,614		1,232,614	(355,112)	877,502			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		335,665	789,265	1,124,930		1,124,930		1,124,930			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			210,407	210,407		210,407		210,407			42
43	Other (specify):*	70,591		3,873	74,464		74,464	(74,464)	(0)			43
44	**TOTAL Special Cost Centers**	70,591	335,665	1,003,545	1,409,801		1,409,801	(74,464)	1,335,337			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,672,948	861,793	4,699,056	8,233,797		8,233,797	(957,964)	7,275,833			45

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

Facility Name & ID Number Rosewood Care Center Of Rockford # 0049270 Report Period Beginning: 07/01/17 Ending: 06/30/18

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(332)	02		4
5	Telephone, TV & Radio in Resident Rooms	(10,293)	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	(89,299)	30		9
10	Interest and Other Investment Income	(475)	32		10
11	Discounts, Allowances, Rebates & Refunds	(4,509)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(399)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,030)	21		18
19	Entertainment	(4)	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	(336,265)	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				28
29	Other-Attach Schedule	(144,471)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (591,077)		$	30

BHF USE ONLY								
48		49		50		51		52	

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 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(366,887)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (366,887)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (957,964)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Rosewood Care Center Of Rockford

ID# 0049270

Report Period Beginning: 07/01/17

Ending: 06/30/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Charges	$ (2,998)	21	1
2	Marketing Salary	(70,590)	43	2
3	Marketing Expense	(3,874)	43	3
4	Resident Reimbursement	(524)	10	4
5	Vending Income	(537)	02	5
6	Miscellaneous Income	(936)	21	6
7	Midcap Line of Credit Fees	(22,653)	36	7
8	Vendor Late Charges	(11,226)	21	8
9	Building Co - Audit Fees	(7,290)	19	9
10	Building Co - Bank Charges	(11,089)	21	10
11	Building Co - Amortization Loan Fee	(4,049)	36	11
12	Non-Allowable Legal	(3,814)	19	12
13	Capitalized R&M	(2,765)	06	13
14	PAC Dues	(2,126)	20	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**	(144,471)		49

Rosewood Care Center Of Rockford

ID# 0049270

Report Period Beginning: 07/01/17

Ending: 06/30/18

	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 Rockford # 0049270 Report Period Beginning: 07/01/17 Ending: 06/30/18

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(5,777)											(5,777)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(10,293)					222	185					(9,887)	5
6	Maintenance	(2,765)					64	(28,957)					(31,659)	6
7	Other (specify):*							3,472					3,472	7
8	**TOTAL General Services**	(18,835)					286	(25,301)					(43,850)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(524)			29,346								28,821	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				2,985								2,985	15
16	**TOTAL Health Care and Programs**	(524)			32,330								31,806	16
	C. General Administration													
17	Administrative			12,401	(116,798)		(192,029)						(296,426)	17
18	Directors Fees													18
19	Professional Services	(11,104)	7,290	17,122	316	(36,814)							(23,190)	19
20	Fees, Subscriptions & Promotions	(2,126)			8	267	2,593	19					760	20
21	Clerical & General Office Expenses	(367,547)	16,489		547	26,498	76,100	377					(247,536)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar				55	198	140						393	24
25	Other Admin. Staff Transportation				3,562	832	5,491	1,907					11,791	25
26	Insurance-Prop.Liab.Malpractice		7,608				4,192	739					12,539	26
27	Other (specify):*				1,919	2,791	20,615						25,325	27
28	**TOTAL General Administration**	(380,777)	31,387	29,523	(110,392)	(6,227)	(82,898)	3,042					(516,344)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(400,136)	31,387	29,523	(78,062)	(6,227)	(82,613)	(22,260)					(528,388)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Center Of Rockford # 0049270 Report Period Beginning: 07/01/17 Ending: 06/30/18

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(89,299)	161,000				7,812	178					79,691	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(475)	357,128	(1,002)			14,083						369,734	32
33	Real Estate Taxes		116,434										116,434	33
34	Rent-Facility & Grounds		(953,135)				14,563						(938,572)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*	(26,703)	44,304										17,601	36
37	TOTAL Ownership	(116,477)	(274,269)	(1,002)			36,458	178					(355,112)	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):*	(74,464)											(74,464)	43
44	TOTAL Special Cost Centers	(74,464)											(74,464)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(591,077)	(242,882)	28,521	(78,062)	(6,227)	(46,155)	(22,081)					(957,964)	45

Facility Name & ID Number Rosewood Care Center Of Rockford # 0049270 Report Period Beginning: 07/01/17 Ending: 06/30/18

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 953,135	Rockford Real Estate		$	$ (953,135)	1
2	V	32	Interest		Rockford Real Estate		357,128	357,128	2
3	V	19	Audit Fees		Rockford Real Estate		7,290	7,290	3
4	V	21	Bank Charges		Rockford Real Estate		11,089	11,089	4
5	V	33	Real Estate Tax		Rockford Real Estate		116,434	116,434	5
6	V	30	Depreciation		Rockford Real Estate		161,000	161,000	6
7	V	36	Amortization Loan Fee		Rockford Real Estate		4,049	4,049	7
8	V	21	Base Admin Fee		Rockford Real Estate		5,400	5,400	8
9	V	26	Insurance		Rockford Real Estate		7,608	7,608	9
10	V	36	MIP Expense		Rockford Real Estate		40,255	40,255	10
11	V								11
12	V								12
13	V								13
14	Total			$ 953,135			$ 710,253	$ * (242,882)	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: 07/01/17 Ending: 06/30/18

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	CONSULTING FEES	$	BRAVO HOLDING COMPANY	100.00%	$ 12,401	$ 12,401	15
16	V	19	PROFESSIONAL FEES		BRAVO HOLDING COMPANY	100.00%	17,122	17,122	16
17	V	32	INTEREST		BRAVO HOLDING COMPANY	100.00%	(1,002)	(1,002)	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			$			$ 28,521	$ * 28,521	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: 07/01/17 Ending: 06/30/18

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	CORPORATE RN SALARIES	$	BRAVO NURSING HOME SERVICES, INC.	100.00%	$ 29,346	$ 29,346	15
16	V	15	CORPORATE RN SALARIES BENEFITS		BRAVO NURSING HOME SERVICES, INC.	100.00%	2,985	2,985	16
17	V	17	ADMINISTRATIVE SALARIES		BRAVO NURSING HOME SERVICES, INC.	100.00%	21,202	21,202	17
18	V	19	PROFESSIONAL FEES		BRAVO NURSING HOME SERVICES, INC.	100.00%	316	316	18
19	V	20	DUES & SUBSCRIPTIONS		BRAVO NURSING HOME SERVICES, INC.	100.00%	8	8	19
20	V	21	OFFICE EXPENSES		BRAVO NURSING HOME SERVICES, INC.	100.00%	547	547	20
21	V	24	SEMINAR & LODGING EXPENSE		BRAVO NURSING HOME SERVICES, INC.	100.00%	55	55	21
22	V	25	AUTO EXPENSE		BRAVO NURSING HOME SERVICES, INC.	100.00%	3,562	3,562	22
23	V	27	ADMINISTRATIVE & OFFICE BENEFITS		BRAVO NURSING HOME SERVICES, INC.	100.00%	1,919	1,919	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			$ 59,938	$ * (78,062)	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: 07/01/17 Ending: 06/30/18

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	$ 1,186	$ 1,186	15
16	V	20	LICENSES		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	267	267	16
17	V	21	LEGAL SALARIES		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	25,268	25,268	17
18	V	21	OFFICE EXPENSE		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	1,230	1,230	18
19	V	24	SEMINAR		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	198	198	19
20	V	25	AUTO / TRAVEL EXPENSE		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	832	832	20
21	V	27	EMPLOYEE BENEFITS		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	2,791	2,791	21
22	V								22
23	V	19	PROFESSIONAL FEES	38,000	CLAIMS ADMINISTRATION SERVICES, LLC	100.00%		(38,000)	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			$ 38,000			$ 31,773	$ * (6,227)	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: 07/01/17 Ending: 06/30/18

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	$ 222	$ 222	15
16	V	6	MAINTENANCE EXPENSE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	64	64	16
17	V	20	DUES, SUBSCRIPTIONS, LICENSES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	2,593	2,593	17
18	V	21	OFFICE SALARIES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	65,224	65,224	18
19	V	21	OFFICE EXPENSES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	16,276	16,276	19
20	V	24	SEMINAR		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	140	140	20
21	V	25	TRAVEL EXPENSE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	5,491	5,491	21
22	V	26	INSURANCE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	4,192	4,192	22
23	V	27	EMPLOYEE BENEFITS		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	20,615	20,615	23
24	V	30	DEPRECIATION		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	7,812	7,812	24
25	V	32	INTEREST		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	14,083	14,083	25
26	V	34	BUILDING RENT		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	14,563	14,563	26
27	V								27
28	V								28
29	V	17	ADMINISTRATIVE FEE	192,029	MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%		(192,029)	29
30	V	21	ADMINISTRATIVE FEE (BLDG CO)	5,400	MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%		(5,400)	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			$ 197,429			$ 151,274	$ * (46,155)	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: 07/01/17 Ending: 06/30/18

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	SENIOR LIVING SERVICES, INC.	100.00%	$ 185	$ 185	15
16	V	6	MAINTENANCE SALARY		SENIOR LIVING SERVICES, INC.	100.00%	24,798	24,798	16
17	V	6	MAINTENANCE EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	2,604	2,604	17
18	V	7	MAINTENANCE BENEFITS		SENIOR LIVING SERVICES, INC.	100.00%	3,472	3,472	18
19	V	20	LICENSES		SENIOR LIVING SERVICES, INC.	100.00%	19	19	19
20	V	21	OFFICE EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	377	377	20
21	V	25	AUTO / TRAVEL EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	1,907	1,907	21
22	V	26	INSURANCE		SENIOR LIVING SERVICES, INC.	100.00%	739	739	22
23	V	30	DEPRECIATION		SENIOR LIVING SERVICES, INC.	100.00%	178	178	23
24	V								24
25	V	6	MAINTENANCE SERVICES	56,695	SENIOR LIVING SERVICES, INC.	100.00%	335	(56,360)	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			$ 56,695			$ 34,614	$ * (22,081)	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: 07/01/17 Ending: 06/30/18

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
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 Rockford # 0049270 Report Period Beginning: 07/01/17 Ending: 06/30/18

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
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 Rockford # 0049270 Report Period Beginning: 07/01/17 Ending: 06/30/18

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
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 Rockford # 0049270 Report Period Beginning: 07/01/17 Ending: 06/30/18

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
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 Rockford # 0049270 Report Period Beginning: 07/01/17 Ending: 06/30/18

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Hinde Feiner	50.00%	Bravo Care of Alton, Inc.	Alton, IL	Rockford Real Estate		Lessor	1
2	Hillel Yampol	50.00%	Bravo Care of East Peoria, Inc.	East Peoria, IL	Bravo Administrative Services, Inc.	St. Louis, MO	Administration	2
3			Bravo Care of Edwardsville, Inc.	Edwardsville, IL	Bravo Holding Company, Inc.	St. Louis, MO	Holding Company	3
4			Bravo Care of Elgin, Inc.	Elgin, IL	Bravo Nursing Home Services, Inc.	St. Louis, MO	Management	4
5			Bravo Care of Galesburg, Inc.	Galesburg, IL	Bravo Team Health, Inc.	St. Louis, MO	Human Resources	5
6			Bravo Care of Inverness, Inc.	Inverness, IL	Claims Administration Services, LL	St. Louis, MO	Legal Services	6
7			Bravo Care of Joliet, Inc.	Joliet, IL	Senior Living Services, Inc.	St. Louis, MO	Building Services	7
8			Bravo Care of Moline, Inc.	Moline, IL	Midwest Administrative Services, In	St. Louis, MO	Administration	8
9			Bravo Care of Northbrook, Inc.	Northbrook, IL	Bravo Care of Wood River, Inc.	Wood River, IL	Supportive Living Facility	9
10			Bravo Care of Peoria, Inc.	Peoria, IL	Rosewood Home Health Services, In	Edwardsville, IL	Home Health	10
11			Bravo Care of St. Charles, Inc.	St. Charles, IL				11
12			Bravo Care of St. Louis, Inc.	St. Louis, MO				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

Facility Name & ID Number Rosewood Care Center Of Rockford # 0049270 Report Period Beginning: 07/01/17 Ending: 06/30/18

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Rosewood Care Center Of Rockford # 0049270 Report Period Beginning: 07/01/17 Ending: 06/30/18

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	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
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: 07/01/17 Ending: 06/30/18

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 [X]

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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 Rockford # 0049270 Report Period Beginning: 07/01/17 Ending: 06/30/18

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	CONSULTING FEES	PATIENT DAYS	445,689	14	$ 200,000	$	27,635	$ 12,401	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	445,689	14	276,131		27,635	17,122	2
3	32	INTEREST	PATIENT DAYS	445,689	14	(16,156)		27,635	(1,002)	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					$ 459,975	$		$ 28,521	25

Facility Name & ID Number Rosewood Care Center Of Rockford # 0049270 Report Period Beginning: 07/01/17 Ending: 06/30/18

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	CORPORATE RN SALARIES	PAT. DAYS	445,689	14	$ 473,276	$ 473,276	27,635	$ 29,346	1
2	15	CORPORATE RN SALARIES BE	PAT. DAYS	445,689	14	48,136		27,635	2,985	2
3	17	ADMINISTRATIVE SALARIES	PAT. DAYS	445,689	14	341,934	341,934	27,635	21,202	3
4	19	PROFESSIONAL FEES	PAT. DAYS	445,689	14	5,100		27,635	316	4
5	20	DUES & SUBSCRIPTIONS	PAT. DAYS	445,689	14	121		27,635	8	5
6	21	OFFICE EXPENSES	PAT. DAYS	445,689	14	8,815		27,635	547	6
7	24	SEMINAR & LODGING EXPENS	PAT. DAYS	445,689	14	888		27,635	55	7
8	25	AUTO EXPENSE	PAT. DAYS	445,689	14	57,444		27,635	3,562	8
9	27	ADMINISTRATIVE & OFFICE B	PAT. DAYS	445,689	14	30,948		27,635	1,919	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					$ 966,663	$ 815,210		$ 59,938	25

Facility Name & ID Number Rosewood Care Center Of Rockford # 0049270 Report Period Beginning: 07/01/17 Ending: 06/30/18

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	ACTUAL FEES	307,124	14	$ 9,587	$	38,000	$ 1,186	1
2	20	LICENSES	ACTUAL FEES	307,124	14	2,155		38,000	267	2
3	21	LEGAL SALARIES	ACTUAL FEES	307,124	14	204,221	204,221	38,000	25,268	3
4	21	OFFICE EXPENSE	ACTUAL FEES	307,124	14	9,942		38,000	1,230	4
5	24	SEMINAR	ACTUAL FEES	307,124	14	1,603		38,000	198	5
6	25	AUTO / TRAVEL EXPENSE	ACTUAL FEES	307,124	14	6,726		38,000	832	6
7	27	EMPLOYEE BENEFITS	ACTUAL FEES	307,124	14	22,559		38,000	2,791	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					$ 256,792	$ 204,221		$ 31,773	25

Facility Name & ID Number Rosewood Care Center Of Rockford # 0049270 Report Period Beginning: 07/01/17 Ending: 06/30/18

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PAT. DAYS	445,689	14	$ 3,576	$	27,635	$ 222	1
2	6	MAINTENANCE EXPENSE	PAT. DAYS	445,689	14	1,030		27,635	64	2
3	20	DUES, SUBSCRIPTIONS, LICEN	PAT. DAYS	445,689	14	41,819		27,635	2,593	3
4	21	OFFICE SALARIES	PAT. DAYS	445,689	14	1,051,919	1,051,919	27,635	65,224	4
5	21	OFFICE EXPENSES	PAT. DAYS	445,689	14	262,500		27,635	16,276	5
6	24	SEMINAR	PAT. DAYS	445,689	14	2,257		27,635	140	6
7	25	TRAVEL EXPENSE	PAT. DAYS	445,689	14	88,555		27,635	5,491	7
8	26	INSURANCE	PAT. DAYS	445,689	14	67,605		27,635	4,192	8
9	27	EMPLOYEE BENEFITS	PAT. DAYS	445,689	14	332,469		27,635	20,615	9
10	30	DEPRECIATION	PAT. DAYS	445,689	14	125,986		27,635	7,812	10
11	32	INTEREST	PAT. DAYS	445,689	14	227,119		27,635	14,083	11
12	34	BUILDING RENT	PAT. DAYS	445,689	14	234,875		27,635	14,563	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					$ 2,439,709	$ 1,051,919		$ 151,274	25

Facility Name & ID Number Rosewood Care Center Of Rockford # 0049270 Report Period Beginning: 07/01/17 Ending: 06/30/18

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	ACTUAL FEES	1,015,133	14	$ 3,306	$	56,695	$ 185	1
2	6	MAINTENANCE SALARY	ACTUAL FEES	1,015,133	14	444,019	444,019	56,695	24,798	2
3	6	MAINTENANCE EXPENSE	ACTUAL FEES	1,015,133	14	46,631		56,695	2,604	3
4	7	MAINTENANCE BENEFITS	ACTUAL FEES	1,015,133	14	62,159		56,695	3,472	4
5	20	LICENSES	ACTUAL FEES	1,015,133	14	332		56,695	19	5
6	21	OFFICE EXPENSE	ACTUAL FEES	1,015,133	14	6,751		56,695	377	6
7	25	AUTO / TRAVEL EXPENSE	ACTUAL FEES	1,015,133	14	34,139		56,695	1,907	7
8	26	INSURANCE	ACTUAL FEES	1,015,133	14	13,240		56,695	739	8
9	30	DEPRECIATION	ACTUAL FEES	1,015,133	14	3,189		56,695	178	9
10										10
11	6	MAINTENANCE SERVICES	DIRECT ALLOCATION		14	4,891			335	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					$ 618,657	$ 444,019		$ 34,614	25

Facility Name & ID Number Rosewood Care Center Of Rockford # 0049270 Report Period Beginning: 07/01/17 Ending: 06/30/18

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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 Rockford # 0049270 Report Period Beginning: 07/01/17 Ending: 06/30/18

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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 Rockford # 0049270 Report Period Beginning: 07/01/17 Ending: 06/30/18

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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 Rockford # 0049270 Report Period Beginning: 07/01/17 Ending: 06/30/18

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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 Rockford # 0049270 Report Period Beginning: 07/01/17 Ending: 06/30/18

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Berkadia		X	Mortgage	$73,916.21	11/01/04	$	$ 9,553,252	12/01/39	0.0470	$ 357,128	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bravo Holding		X	Note Payable				2,713,879			130,935	6
7	MidCap		X	Line of Credit							112,078	7
8	Allocated from Midwest Admin Service		X								14,083	8
9	TOTAL Facility Related				$73,916.21		$	$ 12,267,130			$ 614,224	9
	B. Non-Facility Related*											
10	Interest Income		X								(475)	10
11	Allocated from Bravo Holding Co.		X								(1,002)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,477)	14
15	TOTALS (line 9+line14)						$	$ 12,267,130			$ 612,747	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 40,255 Line # 36

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

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

Facility Name & ID Number Rosewood Care Center Of Rockford # 0049270 Report Period Beginning: 07/01/17 Ending: 06/30/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 128,741	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.)		$ 123,091	2
3. Under or (over) accrual (line 2 minus line 1).		$ (5,650)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 183,677	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.		$ 178,027	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	121,115	8
	2014	121,982	9
	2015	124,529	10
	2016	122,979	11
	2017	123,091	12

Accrued based on PY tax bill.

RE Taxes on Line 2 are the second installment of the 2016 tax bill and the first installment of the 2017 tax bill.

The variance of $61,593 between line 7 above and line 33 on page 4, is the amount of the first installment of the 2017 bill.

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2017	$	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:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rosewood Care Center Of Rockford COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0049270

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2017 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	12-34-102-022	Long Term Care Facility	$ 123,090.70	$ 123,090.70
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 123,090.70	$ 123,090.70

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2017 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2017 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2017.

Please complete the Real Estate Tax Statement below and include it in the 2018 cost report along with a copy of your 2017 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rosewood Care Center Of Rockford COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0049270

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2017 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Rosewood Care Center Of Rockford # 0049270 Report Period Beginning: 07/01/17 Ending: 06/30/18

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 [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	40,042	2013	$ 262,474	1
2					2
3	TOTALS			$ 262,474	3

Facility Name & ID Number Rosewood Care Center Of Rockford # 0049270 Report Period Beginning: 07/01/17 Ending: 06/30/18

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		2013	1996	$ 2,690,005	$ 161,000	40	$ 67,250	$ (93,750)	$ 302,625	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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: 07/01/17 Ending: 06/30/18

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	
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	Related Building Company (Pages 12F & 12G)		52,669			2,424	2,424	6,558	67
68	Related Party Allocations (Pages 12H & 12I)		219	44		44		88	68
69	Financial Statement Depreciation			8,752			(8,752)		69
70	TOTAL (lines 4 thru 69)		$ 2,742,893	$ 169,796		$ 69,718	$ (100,078)	$ 309,271	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: 07/01/17 Ending: 06/30/18

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		$ 2,742,893	$ 169,796		$ 69,718	$ (100,078)	$ 309,271	1
2	Compressor Rotary Repair	2015	2,940		20	147	147	441	2
3	Capacitor Repair	2016	3,363		20	168	168	504	3
4	Smoke Detectors	2017	2,890		20	145	145	289	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)		$ 2,752,086	$ 169,796		$ 70,178	$ (99,618)	$ 310,505	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: 07/01/17 Ending: 06/30/18

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 12B, Carried Forward		$ 2,752,086	$ 169,796		$ 70,178	$ (99,618)	$ 310,505	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,752,086	$ 169,796		$ 70,178	$ (99,618)	$ 310,505	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: 07/01/17 Ending: 06/30/18

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 12C, Carried Forward		$ 2,752,086	$ 169,796		$ 70,178	$ (99,618)	$ 310,505	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,752,086	$ 169,796		$ 70,178	$ (99,618)	$ 310,505	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: 07/01/17 Ending: 06/30/18

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 12D, Carried Forward		$ 2,752,086	$ 169,796		$ 70,178	$ (99,618)	$ 310,505	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,752,086	$ 169,796		$ 70,178	$ (99,618)	$ 310,505	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: 07/01/17 Ending: 06/30/18

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	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Doors	2014	4,774		40	119	119	437	9
10	Doors	2015	8,790		40	220	220	745	10
11	Repair Damaged Roof from Hail Storm	2015	9,520		40	238	238	833	11
12	Seal Coating	2015	4,557		25	182	182	637	12
13	Install (2) Fire Dampers in Mechanical Room	2015	3,275		10	328	328	1,066	13
14	Replace Backflow Preventor	2016	4,993		10	499	499	1,164	14
15	Fire Alarm Control Panel	2016	16,760		20	838	838	1,676	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	$ 2,424	$ 6,558	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: 07/01/17 Ending: 06/30/18

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 12F, Carried Forward		$ 52,669	$		$ 2,424	$ 2,424	$ 6,558	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	$	$ 6,558	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: 07/01/17 Ending: 06/30/18

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	219	44	20	44		88	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)		$ 219	$ 44		$ 44	$	$ 88	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: 07/01/17 Ending: 06/30/18

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 12H, Carried Forward		$ 219	$ 44		$ 44	$	$ 88	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)		$ 219	$ 44		$ 44	$	$ 88	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: 07/01/17 Ending: 06/30/18

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	$ 71,193	$ 2,040	$ 12,081	$ 10,042	10	$ 68,888	71
72	Current Year Purchases	2,765		277	277	10	277	72
73	Fully Depreciated Assets	16,590	149	149		10	16,590	73
74								74
75	TOTALS	$ 90,548	$ 2,188	$ 12,507	$ 10,318		$ 85,754	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	2016	$ 41,609	$ 5,623	$ 5,623	$ 0	5	$ 39,873	76
77		Allocated from Senior Living Serv	2016	8,359	134	134	0	5	8,359	77
78										78
79										79
80	TOTALS			$ 49,968	$ 5,757	$ 5,757	$ 0		$ 48,233	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)	$ 3,155,076	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 177,741	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 88,442	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (89,299)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 444,491	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 Rockford # 0049270 Report Period Beginning: 07/01/17 Ending: 06/30/18

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 [X] 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	Storage				5,061			5
6	Allocated from Midwest Admin Services				14,563			6
7	TOTAL				$ 19,624 **			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: *

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.	/2019	$
13.	/2020	$
14.	/2021	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Rosewood Care Center Of Rockford # 0049270 Report Period Beginning: 07/01/17 Ending: 06/30/18

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Rosewood Care Center Of Rockford # 0049270 Report Period Beginning: 07/01/17 Ending: 06/30/18

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

		1	2	3	4	5	6	7	8	
	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	$		$ 367,432	$		$ 367,432	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			36,631			36,631	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			379,041			379,041	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				314,518		314,518	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					6,161	21,147		27,308	13
14	TOTAL			$		$ 789,265	$ 335,665		$ 1,124,930	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.

STATE OF ILLINOIS

Facility Name & ID Number Rosewood Care Center Of Rockford # 0049270 Report Period Beginning: 07/01/17 Ending: 06/30/18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/18 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 500	$ 500	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,620,637	2,620,637	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	65,941	70,676	6
7	Other Prepaid Expenses		175,254	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	7,888	7,888	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,694,966	$ 2,874,955	10
	B. Long-Term Assets			
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)	(51,178)	(3,402,553)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 378	$ 2,307,342	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,695,344	$ 5,182,297	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,264,006	$ 3,340,376	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,713,879	2,713,879	29
30	Accrued Salaries Payable	136,343	136,343	30
31	Accrued Taxes Payable (excluding real estate taxes)	293,647	293,647	31
32	Accrued Real Estate Taxes(Sch.IX-B)		183,677	32
33	Accrued Interest Payable	130,935	1,429,282	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	3,529	3,529	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	3,066,239	472,865	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 9,608,578	$ 8,573,598	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,553,252	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)**	$	$ 9,553,252	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 9,608,578	$ 18,126,850	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (6,913,234)	$ (12,944,553)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,695,344	$ 5,182,297	48

*(See instructions.)

Facility Name & ID Number Rosewood Care Center Of Rockford # 0049270 Report Period Beginning: 07/01/17 Ending: 06/30/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (5,421,535)	1
2	Restatements (describe):		2
3	Rounding	(3)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (5,421,538)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,491,696)	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)**	$ (1,491,696)	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)**	$ (6,913,234)	24 *

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

Facility Name & ID Number Rosewood Care Center Of Rockford # 0049270 Report Period Beginning: 07/01/17 Ending: 06/30/18

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,302,955	1
2	Discounts and Allowances for all Levels	(2,136,576)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,166,379	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,047,035	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,047,035	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	332	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	396,102	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	42,049	19
20	Radiology and X-Ray	10,698	20
21	Other Medical Services	73,049	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 522,230	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	475	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 475	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	5,982	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,982	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,742,101	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,334,201	31
32	Health Care	2,665,951	32
33	General Administration	1,591,230	33
	B. Capital Expense		
34	Ownership	1,232,614	34
	C. Ancillary Expense		
35	Special Cost Centers	1,199,394	35
36	Provider Participation Fee	210,407	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,233,797	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,491,696)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,491,696)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,251,486	44
45	Private Pay - Net Inpatient Revenue	1,077,032	45
46	Medicare - Net Inpatient Revenue	521,833	46
47	Other-(specify) Managed Care	316,028	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,166,379	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: 07/01/17 Ending: 06/30/18

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,104	2,104	$ 100,230	$ 47.64	1
2	Assistant Director of Nursing	1,094	1,099	44,698	40.67	2
3	Registered Nurses	9,978	10,735	344,812	32.12	3
4	Licensed Practical Nurses	22,969	26,536	755,880	28.49	4
5	CNAs & Orderlies	52,841	56,518	788,751	13.96	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,452	3,963	91,238	23.02	8
9	Activity Director	2,255	2,255	31,056	13.77	9
10	Activity Assistants	3,099	3,113	27,513	8.84	10
11	Social Service Workers	3,757	3,907	62,082	15.89	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	2,187	2,277	40,755	17.90	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,375	2,375	114,212	48.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,086	9,294	129,518	13.94	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	4,240	4,838	71,612	14.80	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	2,958	3,129	70,590	22.56	33
34	TOTAL (lines 1 - 33)	122,395	132,143	$ 2,672,947 *	$ 20.23	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	2,950	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,343	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	2,500	11-03	44
45	Social Service Consultant	Monthly	2,500	12-03	45
46	Other(specify) Outsourced Dietary	Monthly	382,504	01-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 397,797		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	186	$ 7,634	10-03	50
51	Licensed Practical Nurses	963	32,751	10-03	51
52	Certified Nurse Assistants/Aides	19	402	10-03	52
53	TOTAL (lines 50 - 52)	1,169	$ 40,787		53

Facility Name & ID Number Rosewood Care Center Of Rockford # 0049270 Report Period Beginning: 07/01/17 Ending: 06/30/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Shannon Sell	Administrator	0.00%	$ 35,550
C. McBride	Administrator	0.00%	78,662
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 114,212

B. Administrative - Other

Description	Amount
Base Management Fee - Bravo Nursing Home Services	$ 138,000
Base Admin Fee - Midwest Admin Services	36,000
Volume Admin Fee - Midwest Admin Services	156,029
TOTAL (agree to Schedule V, line 17, col. 3)	$ 330,029
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 9,219
Ability Network	Healthcare Technology	4,162
Resolute Healthcare Solutions	Claims Management	3,215
Claims Administrative Services	Related Party Legal	38,000
Infinite Solutions	Support Charges	21,508
See Attached	Legal	18,817
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 94,921

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 78,606
Unemployment Compensation Insurance	43,988
FICA Taxes	198,827
Employee Health Insurance	59,399
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals & Vaccinations	1,428
Employee Drug Tests	228
Dental Insurance	1,891
Employee Relations	2,240
401K Expense	2,671
TOTAL (agree to Schedule V, line 22, col.8)	$ 389,278

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	1,239
Health Care Worker Background Check	3,753
(Indicate # of checks performed 375)	
Patient Background Checks	
Dues and Subscriptions	7,053
License	829
Allocated from Bravo Nursing Home	8
Allocated from Claims Admin Services	267
See Supplemental Schedule	2,612
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,740

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,096
Allocated from Bravo Nursing Home	55
Allocated from Claims Admin Services	198
Allocated from Midwest Admin Services	140
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,489

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Rosewood Care Center Of Rockford # 0049270 Report Period Beginning: 07/01/17 Ending: 06/30/18

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. $ **47,765** 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. $ **210,407**
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. $ Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **332**

(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