

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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 Rockford 61108 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 Charitable Corp. Trust IRS Exemption Code X PROPRIETARY Individual Partnership X Corporation "Sub-S" Corp. Limited Liability Co. Trust Other GOVERNMENTAL State County Other In the event there are further questions about this report, please contact: Name: Steven N. Lavenda Telephone Number: 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 07/01/15 to 06/30/16 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 111 Pfingsten Road, Suite 300 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
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Facility Name & ID Number Rosewood Care Center Of Rockford

0049270 Report Period Beginning: 07/01/15 Ending: 06/30/16

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>120</u>	Skilled (SNF)	<u>120</u>	<u>43,920</u>	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	<u>120</u>	TOTALS	<u>120</u>	<u>43,920</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>15,549</u>	<u>5,516</u>	<u>8,039</u>	<u>29,104</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>15,549</u>	<u>5,516</u>	<u>8,039</u>	<u>29,104</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.27%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

N/A

F. Does the facility maintain a daily midnight census?

YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 12/01/07

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 12/01/07 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number of beds certified 58 and days of care provided 6,040

Medicare Intermediary Novitas Solutions, Inc.

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 06/30/16 Fiscal Year: 06/30/16

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

Facility Name & ID Number Rosewood Care Center Of Rockford # 0049270 Report Period Beginning: 07/01/15 Ending: 06/30/16

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	28,769	3,597	349,640	382,006		382,006	408	382,414			1
2	Food Purchase		223,624		223,624		223,624	(9,501)	214,123			2
3	Housekeeping		17,985	173,975	191,960		191,960		191,960			3
4	Laundry			115,983	115,983		115,983		115,983			4
5	Heat and Other Utilities			127,509	127,509		127,509	(7,243)	120,266			5
6	Maintenance	40,266	5,813	197,091	243,170		243,170	(22,461)	220,709			6
7	Other (specify):*							2,291	2,291			7
8	TOTAL General Services	69,035	251,019	964,198	1,284,252		1,284,252	(36,506)	1,247,746			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,834,611	268,476	547,356	2,650,443		2,650,443	25,854	2,676,297			10
10a	Therapy	55,064	2,279		57,343		57,343		57,343			10a
11	Activities	56,730	4,204	2,200	63,134		63,134		63,134			11
12	Social Services	67,764		2,200	69,964		69,964		69,964			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							2,540	2,540			15
16	TOTAL Health Care and Programs	2,014,169	274,959	551,756	2,840,884		2,840,884	28,394	2,869,278			16
	C. General Administration											
17	Administrative	97,276		345,014	442,290		442,290	(298,619)	143,671			17
18	Directors Fees											18
19	Professional Services			102,347	102,347		102,347	(15,189)	87,158			19
20	Dues, Fees, Subscriptions & Promotions			22,095	22,095		22,095	(486)	21,609			20
21	Clerical & General Office Expenses	119,980	29,503	688,569	838,052		838,052	(522,244)	315,808			21
22	Employee Benefits & Payroll Taxes			308,128	308,128		308,128		308,128			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,068	1,068		1,068	849	1,917			24
25	Other Admin. Staff Transportation			2,298	2,298		2,298	6,234	8,532			25
26	Insurance-Prop.Liab.Malpractice			62,859	62,859		62,859	13,402	76,261			26
27	Other (specify):*							20,458	20,458			27
28	TOTAL General Administration	217,256	29,503	1,532,378	1,779,137		1,779,137	(795,593)	983,544			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,300,460	555,481	3,048,332	5,904,273		5,904,273	(803,706)	5,100,567			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.

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			10,571	10,571		10,571	83,893	94,464			30
31	Amortization of Pre-Op. & Org.							0	0			31
32	Interest			226,120	226,120		226,120	468,881	695,001			32
33	Real Estate Taxes							124,422	124,422			33
34	Rent-Facility & Grounds			957,343	957,343		957,343	(940,506)	16,837			34
35	Rent-Equipment & Vehicles							19	19			35
36	Other (specify):*			15,630	15,630		15,630	33,019	48,649			36
37	TOTAL Ownership			1,209,664	1,209,664		1,209,664	(230,273)	979,391			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		312,455	796,851	1,109,306		1,109,306		1,109,306			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			205,308	205,308		205,308		205,308			42
43	Other (specify):*	83,526		1,940	85,466		85,466	(85,466)				43
44	TOTAL Special Cost Centers	83,526	312,455	1,004,099	1,400,080		1,400,080	(85,466)	1,314,614			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,383,986	867,936	5,262,095	8,514,017		8,514,017	(1,119,445)	7,394,572			45

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

VI. ADJUSTMENT DETAIL

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

	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	(1,444)	02		4
5	Telephone, TV & Radio in Resident Rooms	(7,492)	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	(96,515)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(424)	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				18
19	Entertainment	(15)	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	(452,043)	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	(232)	20		28
29	Other-Attach Schedule	(356,946)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (915,111)		\$	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)	(204,334)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (204,334)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,119,445)		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

Report Period Beginning:

Ending:

ID#

0049270

07/01/15

06/30/16

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Bank Charges	\$ (2,909)	21	1
2	Vending Income	(1,306)	02	2
3	PAC Dues	(2,588)	20	3
4	Midcap Credit Fees	(15,630)	36	4
5	Hospice AR Reserve	(187,604)	21	5
6	Marketing Salary	(83,526)	43	6
7	Marketing Expense	(1,940)	43	7
8	Resident Reimbursement	(115)	10	8
9	Vendor Discount	(6,327)	02	9
10	Miscellaneous Income	(3,255)	21	10
11	Vendor Late Charges	(17,093)	21	11
12	Marketing Travel	(1,440)	25	12
13	Bldg. Co. - Audit Fees	(4,100)	19	13
14	Bldg. Co. - Pro. Fees	(883)	19	14
15	Bldg.Co.- Bank Fees	(13,307)	21	15
16	Bldg. Co.-Amortization	(4,859)	31	16
17	Capitalized R& M	(6,303)	06	17
18	Non Allowable Legal Fees	(3,761)	19	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	(356,946)		49

ID#

0049270

Report Period Beginning:

07/01/15

Ending:

06/30/16

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: 07/01/15 Ending: 06/30/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				408								408	1
2	Food Purchase	(9,501)											(9,501)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(7,492)		140				110					(7,243)	5
6	Maintenance	(6,303)		84				(16,243)					(22,461)	6
7	Other (specify):*				43			2,247					2,291	7
8	TOTAL General Services	(23,296)		224	451			(13,885)					(36,506)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(115)			25,969								25,854	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				2,540								2,540	15
16	TOTAL Health Care and Programs	(115)			28,509								28,394	16
	C. General Administration													
17	Administrative			(207,014)	(97,879)	6,273							(298,619)	17
18	Directors Fees													18
19	Professional Services	(8,744)	4,983	101	73	16,697	(28,354)	53					(15,189)	19
20	Fees, Subscriptions & Promotions	(2,820)		2,050	2	214	17	51					(486)	20
21	Clerical & General Office Expenses	(676,226)	20,507	128,763	409	289	3,821	193					(522,244)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			421	149	258	22						849	24
25	Other Admin. Staff Transportation	(1,440)		2,130	2,692	1,304	235	1,314					6,234	25
26	Insurance-Prop.Liab.Malpractice		9,270	3,691				442					13,402	26
27	Other (specify):*			17,005	3,228		225						20,458	27
28	TOTAL General Administration	(689,230)	34,760	(52,853)	(91,326)	25,036	(24,033)	2,053					(795,593)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(712,641)	34,760	(52,629)	(62,366)	25,036	(24,033)	(11,832)					(803,706)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Center Of Rockford # 0049270 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	(96,515)	165,985	13,930				492					83,893	30
31	Amortization of Pre-Op. & Org.	(4,859)	4,859										0	31
32	Interest		454,038	15,941		(1,098)							468,881	32
33	Real Estate Taxes		124,422										124,422	33
34	Rent-Facility & Grounds		(953,461)	12,955									(940,506)	34
35	Rent-Equipment & Vehicles				8	5		5					19	35
36	Other (specify):*	(15,630)	48,649										33,019	36
37	TOTAL Ownership	(117,004)	(155,508)	42,826	8	(1,092)		497					(230,273)	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):*	(85,466)											(85,466)	43
44	TOTAL Special Cost Centers	(85,466)											(85,466)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(915,111)	(120,749)	(9,803)	(62,357)	23,944	(24,033)	(11,335)					(1,119,445)	45

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENTAL INCOME	\$ 953,461	Rockford Real Estate	100.00%	\$	(953,461)	1
2	V	32	INT INCOME - ESCROW	35	Rockford Real Estate	100.00%		(35)	2
3	V	19	AUDIT FEES - HB&CO		Rockford Real Estate	100.00%	4,100	4,100	3
4	V	19	PROFESSIONAL FEES		Rockford Real Estate	100.00%	883	883	4
5	V	21	BANK CHARGES		Rockford Real Estate	100.00%	13,307	13,307	5
6	V	32	INT EXPENSE - HUD MORTGAGE		Rockford Real Estate	100.00%	454,073	454,073	6
7	V	36	INT EXPENSE - HUD MIP		Rockford Real Estate	100.00%	48,649	48,649	7
8	V	33	REAL ESTATE TAX		Rockford Real Estate	100.00%	124,422	124,422	8
9	V	30	DEPRECIATION		Rockford Real Estate	100.00%	165,985	165,985	9
10	V	31	AMORTIZATION LOAN FEE		Rockford Real Estate	100.00%	4,859	4,859	10
11	V	21	BASE ADMIN FEE (PAGE 6A)		Rockford Real Estate	100.00%	7,200	7,200	11
12	V	26	INSURANCE EXPENSE - PROPERTY		Rockford Real Estate	100.00%	9,270	9,270	12
13	V								13
14	Total			\$ 953,496			\$ 832,747	\$ * (120,749)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	\$ 140	\$ 140	15
16	V	6	MAINTENANCE EXPENSE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	84	84	16
17	V	19	PROFESSIONAL FEES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	101	101	17
18	V	20	DUES, SUBSCRIPTIONS, LICENSES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	2,050	2,050	18
19	V	21	OFFICE SALARIES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	107,069	107,069	19
20	V	21	OFFICE EXPENSES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	28,895	28,895	20
21	V	24	SEMINAR		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	421	421	21
22	V	25	TRAVEL EXPENSE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	2,130	2,130	22
23	V	26	INSURANCE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	3,691	3,691	23
24	V	27	EMPLOYEE BENEFITS		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	17,005	17,005	24
25	V	30	DEPRECIATION		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	13,930	13,930	25
26	V	32	INTEREST		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	15,941	15,941	26
27	V	34	BUILDING RENT		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	12,955	12,955	27
28	V								28
29	V	17	ADMINISTRATIVE FEE	207,014	MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%		(207,014)	29
30	V	21	ADMINISTRATIVE FEE (BLDG CO)	7,200	MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%		(7,200)	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 214,214			\$ 204,411	\$ * (9,803)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARY	\$	BRAVO NURSING HOME SERVICES, INC.	100.00%	\$ 408	\$ 408	15
16	V	7	DIETARY BENEFITS		BRAVO NURSING HOME SERVICES, INC.	100.00%	43	43	16
17	V	10	CORPORATE RN SALARIES		BRAVO NURSING HOME SERVICES, INC.	100.00%	25,969	25,969	17
18	V	15	CORPORATE RN SALARIES BENEFITS		BRAVO NURSING HOME SERVICES, INC.	100.00%	2,540	2,540	18
19	V	17	ADMINISTRATIVE SALARIES		BRAVO NURSING HOME SERVICES, INC.	100.00%	40,121	40,121	19
20	V	19	PROFESSIONAL FEES		BRAVO NURSING HOME SERVICES, INC.	100.00%	73	73	20
21	V	20	DUES & SUBSCRIPTIONS		BRAVO NURSING HOME SERVICES, INC.	100.00%	2	2	21
22	V	21	OFFICE EXPENSES		BRAVO NURSING HOME SERVICES, INC.	100.00%	409	409	22
23	V	24	SEMINAR & LODGING EXPENSE		BRAVO NURSING HOME SERVICES, INC.	100.00%	149	149	23
24	V	25	AUTO EXPENSE		BRAVO NURSING HOME SERVICES, INC.	100.00%	2,692	2,692	24
25	V	27	ADMINISTRATIVE & OFFICE BENEFITS		BRAVO NURSING HOME SERVICES, INC.	100.00%	3,228	3,228	25
26	V	35	AUTO LEASE		BRAVO NURSING HOME SERVICES, INC.	100.00%	8	8	26
27	V								27
28	V	17	ADMINISTRATIVE FEE	138,000	BRAVO NURSING HOME SERVICES, INC.	100.00%		(138,000)	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 138,000			\$ 75,643	\$ * (62,357)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	CONSULTING FEES	\$	BRAVO HOLDING COMPANY	100.00%	\$ 6,273	\$ 6,273	15
16	V	19	PROFESSIONAL FEES		BRAVO HOLDING COMPANY	100.00%	16,697	16,697	16
17	V	20	DUES & SUBSCRIPTIONS		BRAVO HOLDING COMPANY	100.00%	214	214	17
18	V	21	OFFICE EXPENSE		BRAVO HOLDING COMPANY	100.00%	289	289	18
19	V	24	SEMINAR EXPENSE		BRAVO HOLDING COMPANY	100.00%	258	258	19
20	V	25	AUTO & TRAVEL EXPENSE		BRAVO HOLDING COMPANY	100.00%	1,304	1,304	20
21	V	32	INTEREST		BRAVO HOLDING COMPANY	100.00%	(1,098)	(1,098)	21
22	V	35	AUTO RENTAL		BRAVO HOLDING COMPANY	100.00%	5	5	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 23,944	\$ * 23,944	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	\$	CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	\$ 108	\$ 108	15
16	V	20	LICENSES		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	17	17	16
17	V	21	OFFICE SALARIES		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	3,742	3,742	17
18	V	21	OFFICE EXPENSE		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	79	79	18
19	V	24	SEMINAR		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	22	22	19
20	V	25	AUTO / TRAVEL EXPENSE		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	235	235	20
21	V	27	EMPLOYEE BENEFITS		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	225	225	21
22	V								22
23	V	19	PROFESSIONAL FEES	28,462	CLAIMS ADMINISTRATION SERVICES, LLC	100.00%		(28,462)	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			\$ 28,462			\$ 4,429	\$ * (24,033)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	SENIOR LIVING SERVICES, INC.	100.00%	\$ 110	\$ 110	15
16	V	6	MAINTENANCE SALARY		SENIOR LIVING SERVICES, INC.	100.00%	15,851	15,851	16
17	V	6	MAINTENANCE EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	1,608	1,608	17
18	V	7	MAINTENANCE BENEFITS		SENIOR LIVING SERVICES, INC.	100.00%	2,247	2,247	18
19	V	19	PROFESSIONAL FEES		SENIOR LIVING SERVICES, INC.	100.00%	53	53	19
20	V	20	LICENSES		SENIOR LIVING SERVICES, INC.	100.00%	51	51	20
21	V	21	OFFICE EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	193	193	21
22	V	25	AUTO / TRAVEL EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	1,314	1,314	22
23	V	26	INSURANCE		SENIOR LIVING SERVICES, INC.	100.00%	442	442	23
24	V	30	DEPRECIATION		SENIOR LIVING SERVICES, INC.	100.00%	492	492	24
25	V	35	AUTO LEASE		SENIOR LIVING SERVICES, INC.	100.00%	5	5	25
26	V	6	MAINTENANCE SUPPLIES		SENIOR LIVING SERVICES, INC.	100.00%	166	166	26
27	V								27
28	V	6	MAINTENANCE SERVICES	33,868	SENIOR LIVING SERVICES, INC.	100.00%		(33,868)	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			\$ 33,868			\$ 22,533	\$ * (11,335)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

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

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

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

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

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

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

VII. RELATED PARTIES

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, LLC	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, Inc.	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, Inc.	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

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

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Hillel Yampol	Shareholder	Administrative	50.00%	See Attached	1.25	6.25%	Alloc. Salary	\$ 1,423	17-7	1
2	Mark Yampol	Relative	Administrative	0	See Attached	1.25	6.25%	Alloc. Fee	6,273	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 7,696		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

Ending: 06/30/16

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

Ending: 06/30/16

(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	463,927	14	\$ 2,224	\$	29,104	\$ 140	1
2	6	MAINTENANCE EXPENSE	PAT. DAYS	463,927	14	1,345		29,104	84	2
3	19	PROFESSIONAL FEES	PAT. DAYS	463,927	14	1,614		29,104	101	3
4	20	DUES, SUBSCRIPTIONS, LICEN	PAT. DAYS	463,927	14	32,685		29,104	2,050	4
5	21	OFFICE SALARIES	PAT. DAYS	463,927	14	1,706,712	1,706,712	29,104	107,069	5
6	21	OFFICE EXPENSES	PAT. DAYS	463,927	14	460,588		29,104	28,895	6
7	24	SEMINAR	PAT. DAYS	463,927	14	6,706		29,104	421	7
8	25	TRAVEL EXPENSE	PAT. DAYS	463,927	14	33,946		29,104	2,130	8
9	26	INSURANCE	PAT. DAYS	463,927	14	58,834		29,104	3,691	9
10	27	EMPLOYEE BENEFITS	PAT. DAYS	463,927	14	271,068		29,104	17,005	10
11	30	DEPRECIATION	PAT. DAYS	463,927	14	222,055		29,104	13,930	11
12	32	INTEREST	PAT. DAYS	463,927	14	254,102		29,104	15,941	12
13	34	BUILDING RENT	PAT. DAYS	463,927	14	206,500		29,104	12,955	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,258,379	\$ 1,706,712		\$ 204,412	25

Ending: 06/30/16

(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	1	DIETARY SALARY	PAT. DAYS	463,927	14	\$ 6,505	\$ 6,505	29,104	\$ 408	1
2	7	DIETARY BENEFITS	PAT. DAYS	463,927	14	687		29,104	43	2
3	10	CORPORATE RN SALARIES	PAT. DAYS	463,927	14	413,960	413,960	29,104	25,969	3
4	15	CORPORATE RN SALARIES BE	PAT. DAYS	463,927	14	40,484		29,104	2,540	4
5	17	ADMINISTRATIVE SALARIES	PAT. DAYS	463,927	14	639,544	639,544	29,104	40,121	5
6	19	PROFESSIONAL FEES	PAT. DAYS	463,927	14	1,170		29,104	73	6
7	20	DUES & SUBSCRIPTIONS	PAT. DAYS	463,927	14	27		29,104	2	7
8	21	OFFICE EXPENSES	PAT. DAYS	463,927	14	6,517		29,104	409	8
9	24	SEMINAR & LODGING EXPEN	PAT. DAYS	463,927	14	2,370		29,104	149	9
10	25	AUTO EXPENSE	PAT. DAYS	463,927	14	42,910		29,104	2,692	10
11	27	ADMINISTRATIVE & OFFICE I	PAT. DAYS	463,927	14	51,458		29,104	3,228	11
12	35	AUTO LEASE	PAT. DAYS	463,927	14	133		29,104	8	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,205,766	\$ 1,060,009		\$ 75,642	25

Ending: 06/30/16

(314) 994-9912

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6			
1	17	CONSULTING FEES	PATIENT DAYS	463,927	14	\$ 100,000	\$ 29,104	\$ 6,273	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	463,927	14	266,160	29,104	16,697	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	463,927	14	3,410	29,104	214	3
4	21	OFFICE EXPENSE	PATIENT DAYS	463,927	14	4,609	29,104	289	4
5	24	SEMINAR EXPENSE	PATIENT DAYS	463,927	14	4,112	29,104	258	5
6	25	AUTO & TRAVEL EXPENSE	PATIENT DAYS	463,927	14	20,788	29,104	1,304	6
7	32	INTEREST	PATIENT DAYS	463,927	14	(17,495)	29,104	(1,098)	7
8	35	AUTO RENTAL	PATIENT DAYS	463,927	14	85	29,104	5	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					\$ 381,668	\$	\$ 23,942	25

Ending: 06/30/16

(314) 994-9912

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6			
1	19	PROFESSIONAL FEES	ACTUAL FEES	667,999	13	\$ 6,309	\$ 11,462	\$ 108	1
2	20	LICENSES	ACTUAL FEES	667,999	13	1,000	11,462	17	2
3	21	OFFICE SALARIES	ACTUAL FEES	667,999	13	218,085	11,462	3,742	3
4	21	OFFICE EXPENSE	ACTUAL FEES	667,999	13	4,612	11,462	79	4
5	24	SEMINAR	ACTUAL FEES	667,999	13	1,281	11,462	22	5
6	25	AUTO / TRAVEL EXPENSE	ACTUAL FEES	667,999	13	13,694	11,462	235	6
7	27	EMPLOYEE BENEFITS	ACTUAL FEES	667,999	13	13,112	11,462	225	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					\$ 258,092	\$ 218,085	\$ 4,428	25

Ending: 06/30/16

(314) 994-9912

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6			
1	5	UTILITIES	ACTUAL FEES	929,714	14	\$ 3,017	\$ 33,868	\$ 110	1
2	6	MAINTENANCE SALARY	ACTUAL FEES	929,714	14	435,123	33,868	15,851	2
3	6	MAINTENANCE EXPENSE	ACTUAL FEES	929,714	14	44,153	33,868	1,608	3
4	7	MAINTENANCE BENEFITS	ACTUAL FEES	929,714	14	61,694	33,868	2,247	4
5	19	PROFESSIONAL FEES	ACTUAL FEES	929,714	14	1,467	33,868	53	5
6	20	LICENSES	ACTUAL FEES	929,714	14	1,402	33,868	51	6
7	21	OFFICE EXPENSE	ACTUAL FEES	929,714	14	5,306	33,868	193	7
8	25	AUTO / TRAVEL EXPENSE	ACTUAL FEES	929,714	14	36,073	33,868	1,314	8
9	26	INSURANCE	ACTUAL FEES	929,714	14	12,121	33,868	442	9
10	30	DEPRECIATION	ACTUAL FEES	929,714	14	13,517	33,868	492	10
11	35	AUTO LEASE	ACTUAL FEES	929,714	14	135	33,868	5	11
12	6	MAINTENANCE SUPPLIES	DIRECT ALLOCATION	13	6,541			166	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					\$ 620,549	\$ 435,123	\$ 22,532	25

Ending: 06/30/16

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

Ending: 06/30/16

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: 07/01/15 Ending: 06/30/16

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office
or parent organization costs? (See instructions.) YES ☐ NO ☐

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Ending: 06/30/16

	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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Berkadia		X	Mortgage	73916.21	11/1/04	\$ 4,941,300	\$ 9,670,313	12/1/39	0.0470	\$ 454,073	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Bravo Holding		X	Note Payable				3,022,790			151,090	6	
7	MidCap		X	Line of Credit							75,030	7	
8												8	
9	TOTAL Facility Related				73916.21		\$ 4,941,300	\$ 12,693,104			\$ 680,193	9	
	B. Non-Facility Related*												
10	Bldg. Co. Interest Income		X								(35)	10	
11	Allocated from MAS	X									15,941	11	
12	Allocated from Bravo Holding C	X									(1,098)	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 14,808	14	
15	TOTALS (line 9+line14)						\$ 4,941,300	\$ 12,693,104			\$ 695,001	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 48,649 Line # 36

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related Long-Term																		
1							\$		\$			\$							1
2																			2
3																			3
4																			4
5																			5
6																			6
7	TOTAL Long-Term																		7
	Working Capital																		
8							\$		\$			\$							8
9																			9
10																			10
11																			11
12																			12
13																			13
14	TOTAL Working Capital																		14
	B. Non-Facility Related*																		
15							\$		\$			\$							15
16																			16
17																			17
18																			18
19																			19
20	TOTAL Non-Facility Related																		20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	125,526	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.)				\$	123,255	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(2,271)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	126,692	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.				\$	124,421	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2011	119,752	8	FOR BHF USE ONLY	
		2012	118,352	9		
		2013	121,115	10		
		2014	121,982	11		
		2015	124,529	12		
Accrual based on PY tax bill.				13	FROM R. E. TAX STATEMENT FOR 2015	13
RE Taxes paid on Line 2 are the second installment of the 2014 tax bill and the first installment of the 2015 tax bill.				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.

2015 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

Steve Lavenda

TELEPHONE

(847) 236-6300

FAX #:

(847) 236-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1. <u>12-34-102-022</u>	<u>Long Term Care Facility</u>	\$ <u>124,528.72</u>	\$ <u>124,528.72</u>
2. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS		\$ <u>124,528.72</u>	\$ <u>124,528.72</u>

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 2015 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 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 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.

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 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.

FACILITY NAME Rosewood Care Center Of Rockford COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0049270

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

Enter the tax index number and real estate tax assessed for 2015 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 2015.

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?

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.)

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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.

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

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	120		2013	1996	\$ 2,690,005	\$ 165,985	40	\$ 67,250	\$ (98,735)	\$ 168,125	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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67	Related Building Company (Pages 12F & 12G)	35,909			1,253	1,253	1,710	67
68	Related Party Allocations (Pages 12H & 12I)							68
69	Financial Statement Depreciation		10,571			(10,571)		69
70	TOTAL (lines 4 thru 69)	\$ 2,725,914	\$ 176,556		\$ 68,503	\$ (108,053)	\$ 169,835	70

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward	\$ 2,725,914	\$ 176,556		\$ 68,503	\$ (108,053)	\$ 169,835	1
2	Compressor Rotary Repair	2015	2,940	20	147	147	147	2
3	Capacitor Repair	2016	3,363	20	168	168	168	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)	\$ 2,732,217	\$ 176,556		\$ 68,818	\$ (107,738)	\$ 170,150	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,732,217	\$ 176,556		\$ 68,818	\$ (107,738)	\$ 170,150	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)		\$ 2,732,217	\$ 176,556		\$ 68,818	\$ (107,738)	\$ 170,150	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,732,217	\$ 176,556		\$ 68,818	\$ (107,738)	\$ 170,150	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
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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)		\$ 2,732,217	\$ 176,556		\$ 68,818	\$ (107,738)	\$ 170,150	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 2,732,217	\$ 176,556		\$ 68,818	\$ (107,738)	\$ 170,150	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
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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)		\$ 2,732,217	\$ 176,556		\$ 68,818	\$ (107,738)	\$ 170,150	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:

07/01/15

Ending:

06/30/16

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	199	9
10	Doors	2015	8,790		40	220	220	305	10
11	Repair Damaged Roof from Hail Storm	2015	9,520		40	238	238	357	11
12	Seal Coating	2015	4,557		25	182	182	273	12
13	Install (2) Fire Dampers in Mechanical Room	2015	3,275		10	328	328	410	13
14	Replace Backflow Preventor	2016	4,993		10	166	166	166	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)		\$ 35,909	\$		\$ 1,253	\$ 1,253	\$ 1,710	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$35,909	\$		\$1,253	\$1,253	\$1,710	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)		\$35,909	\$		\$1,253	\$1,253	\$1,710	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									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)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$73,514	\$2,532	\$13,755	\$11,223	10	\$45,311	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	14,587	108	108		10	14,587	73
74								74
75	TOTALS	\$88,101	\$2,640	\$13,863	\$11,223		\$59,898	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	various	\$44,284	\$11,290	\$11,290		5	\$28,783	76
77		Allocated from Senior Living Ser	various	5,453	492	492		5	5,102	77
78										78
79										79
80	TOTALS			\$49,737	\$11,782	\$11,782			\$33,885	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)	\$3,132,529	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$190,978	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$94,463	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(96,515)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$263,933	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES
- ☒ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Off-Site Storage				3,882			5
6	Allocated from MAS				12,955			6
7	TOTAL				\$ 16,837			7

**

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

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

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☒ NO

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

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Bravo Nursing Home		\$	\$ 8	17
18	Allocated from Bravo Holding Company			5	18
19	Allocated from Senior Living Services			5	19
20					20
21	TOTAL		\$	\$ 18	21

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2017	\$
13.	/2018	\$
14.	/2019	\$

* 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.

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

☒ 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.

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	\$		\$	379,681	\$		\$	379,681	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				35,088				35,088	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				371,231				371,231	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					294,480			294,480	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify): See Supplemental						10,851	17,975			28,826	13
14	TOTAL			\$		\$	796,851	\$	312,455	\$	1,109,306	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.

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	\$ 997	\$ 5,375	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,856,405	1,856,405	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	43,729	47,205	6
7	Other Prepaid Expenses		184,162	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	7,888	124,951	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,909,019	\$ 2,218,098	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	651,173	16
17	Accumulated Depreciation (book methods)	(32,115)	(3,057,682)	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)	\$ 19,441	\$ 2,632,246	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,928,460	\$ 4,850,344	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,310,193	\$ 2,341,844	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	3,022,790	3,022,790	29
30	Accrued Salaries Payable	134,004	134,004	30
31	Accrued Taxes Payable (excluding real estate taxes)	148,638	148,638	31
32	Accrued Real Estate Taxes(Sch.IX-B)		126,692	32
33	Accrued Interest Payable		508,142	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	3,529	3,529	35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	1,339,563	324,960	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,958,717	\$ 6,610,599	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,670,313	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)	\$	\$ 9,670,313	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,958,717	\$ 16,280,912	46
47	TOTAL EQUITY(page 18, line 24)	\$ (5,030,257)	\$ (11,430,568)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,928,460	\$ 4,850,344	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,596,260)	1
2	Restatements (describe):		2
3	Prior Year Adjustment	(745)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,597,005)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,433,252)	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)	\$ (1,433,252)	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)	\$ (5,030,257)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,864,213	1
2	Discounts and Allowances for all Levels	(2,452,313)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,411,900	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,245,448	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,245,448	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	800	13
14	Non-Patient Meals	1,444	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	238,675	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	65,988	19
20	Radiology and X-Ray	8,524	20
21	Other Medical Services	97,098	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 412,529	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	10,888	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 10,888	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,080,765	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,284,252	31
32	Health Care	2,840,884	32
33	General Administration	1,779,137	33
B. Capital Expense			
34	Ownership	1,209,664	34
C. Ancillary Expense			
35	Special Cost Centers	1,194,772	35
36	Provider Participation Fee	205,308	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,514,017	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,433,252)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,433,252)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,316,705	44
45	Private Pay - Net Inpatient Revenue	953,986	45
46	Medicare - Net Inpatient Revenue	928,549	46
47	Other-(specify) Managed Care	212,660	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,411,900	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.

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,157	2,290	\$ 92,233	\$ 40.28	1
2	Assistant Director of Nursing	2,378	2,562	92,424	36.07	2
3	Registered Nurses	16,478	17,790	474,376	26.67	3
4	Licensed Practical Nurses	14,085	15,015	354,958	23.64	4
5	CNAs & Orderlies	59,786	62,466	753,771	12.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,918	3,078	55,064	17.89	8
9	Activity Director	2,147	2,326	27,439	11.80	9
10	Activity Assistants	3,451	3,563	29,291	8.22	10
11	Social Service Workers	4,373	4,509	67,764	15.03	11
12	Dietician					12
13	Food Service Supervisor	264	272	3,930	14.45	13
14	Head Cook					14
15	Cook Helpers/Assistants	2,033	2,640	24,839	9.41	15
16	Dishwashers					16
17	Maintenance Workers	2,375	2,606	40,266	15.45	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,080	2,128	97,276	45.71	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,987	9,716	119,980	12.35	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	4,576	4,776	66,849	14.00	31
32	Other Health Care(specify)					32
33	Other(specify)	3,691	4,060	83,526	20.57	33
34	TOTAL (lines 1 - 33)	131,779	139,797	\$ 2,383,986 *	\$ 17.05	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 1,340	01-03	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,908	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	2,200	11-03	44
45	Social Service Consultant	Monthly	2,200	12-03	45
46	Other(specify)				46
47	Outsourced Dietary	Monthly	348,300	01-03	47
48					48
49	TOTAL (lines 35 - 48)		\$ 361,948		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	5,537	\$ 227,033	10-03	50
51	Licensed Practical Nurses	6,137	208,649	10-03	51
52	Certified Nurse Assistants/Aides	4,941	103,766	10-03	52
53	TOTAL (lines 50 - 52)	16,615	\$ 539,448		53

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

** See instructions.

Facility Name & ID Number		Rosewood Care Center Of Rockford		STATE OF ILLINOIS	#	0049270	Report Period Beginning:	07/01/15	Ending:	06/30/16	Page 22
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 \$6,869							
(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.			\$		53,214		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.			\$		205,308					
	This amount is to be recorded on line 42 of Schedule V.										
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?			No		If YES, attach an explanation of the allocation.					
(13)	Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?			Yes							
(14)	Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?			No		For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.					
(15)	Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.			\$		Yes		Has any meal income been offset against related costs?		Indicate the amount. \$	
										1,444	
(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		100% Ln 14					
	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?			Yes		See page 39 of the instructions for details. Attach invoices and a summary of services for all architect and appraisal fees					