

Facility Name & ID Number Rosewood Care Ctr Galesburg

0049791 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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	180	Skilled (SNF)	180	65,700	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	180	TOTALS	180	65,700	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	17,642	12,251	3,819	33,712	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,642	12,251	3,819	33,712	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 51.31%

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

0 (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)

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 Non-allowable costs have been eliminated in Schedule V, Column 7

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 5/1/2008

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

YES Date 5/1/2008 NO

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

YES NO If YES, enter number of beds certified 180 and days of care provided 3,129

Medicare Intermediary Novitas Solutions, Inc.

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/14 Fiscal Year: 06/30/14

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

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	248,723	16,753	7,686	273,162		273,162	1,650	274,812	1	
2	Food Purchase		217,498		217,498		217,498	(13,238)	204,260	2	
3	Housekeeping	206,913	40,503		247,416		247,416		247,416	3	
4	Laundry	58,314	12,685		70,999		70,999		70,999	4	
5	Heat and Other Utilities			164,128	164,128		164,128	216	164,344	5	
6	Maintenance	30,968	5,923	282,739	319,630		319,630	(77,647)	241,983	6	
7	Other (specify):* Allocated HO Benefits							4,409	4,409	7	
8	TOTAL General Services	544,918	293,362	454,553	1,292,833		1,292,833	(84,610)	1,208,223	8	
	B. Health Care and Programs										
9	Medical Director			9,875	9,875		9,875		9,875	9	
10	Nursing and Medical Records	2,253,443	168,430	17,487	2,439,360		2,439,360	45,638	2,484,998	10	
10a	Therapy		666	347,829	348,495		348,495		348,495	10a	
11	Activities	49,527	3,739	2,400	55,666		55,666		55,666	11	
12	Social Services	57,022		2,600	59,622		59,622		59,622	12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):* Allocated HO Benefits							3,847	3,847	15	
16	TOTAL Health Care and Programs	2,359,992	172,835	380,191	2,913,018		2,913,018	49,485	2,962,503	16	
	C. General Administration										
17	Administrative	86,886		215,725	302,611		302,611	(199,667)	102,944	17	
18	Directors Fees									18	
19	Professional Services			104,307	104,307		104,307	98,620	202,927	19	
20	Dues, Fees, Subscriptions & Promotions			22,186	22,186		22,186	(2,258)	19,928	20	
21	Clerical & General Office Expenses	107,745	11,786	40,493	160,024		160,024	151,206	311,230	21	
22	Employee Benefits & Payroll Taxes			407,061	407,061		407,061		407,061	22	
23	Inservice Training & Education									23	
24	Travel and Seminar			245	245		245	6,193	6,438	24	
25	Other Admin. Staff Transportation			8,539	8,539		8,539	4,056	12,595	25	
26	Insurance-Prop.Liab.Malpractice			33,804	33,804		33,804	8,945	42,749	26	
27	Other (specify):* Allocated HO Benefits							14,339	14,339	27	
28	TOTAL General Administration	194,631	11,786	832,360	1,038,777		1,038,777	81,434	1,120,211	28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,099,541	477,983	1,667,104	5,244,628		5,244,628	46,309	5,290,937	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 Ctr Galesburg

#0049791

Report Period Beginning: 07/01/2013 Ending: 06/30/2014

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			16,304	16,304		16,304	86,267	102,571			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			203,596	203,596		203,596	351,840	555,436			32
33	Real Estate Taxes			71,113	71,113		71,113	78,258	149,371			33
34	Rent-Facility & Grounds			900,000	900,000		900,000	(444,321)	455,679			34
35	Rent-Equipment & Vehicles			30,973	30,973		30,973	9,839	40,812			35
36	Other (specify):*											36
37	TOTAL Ownership			1,221,986	1,221,986		1,221,986	81,883	1,303,869			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		118,518		118,518		118,518		118,518			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			287,266	287,266		287,266		287,266			42
43	Other (specify):* See Att Sch 4A	79,051		56,368	135,419		135,419	(125,600)	9,819			43
44	TOTAL Special Cost Centers	79,051	118,518	343,634	541,203		541,203	(125,600)	415,603			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,178,592	596,501	3,232,724	7,007,817		7,007,817	2,592	7,010,409			45

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

Rosewood Care Ctr Galesburg

Period Beginning 07/01/2013

Period End 06/30/2014

Schedule 4A

V. Cost Center Expenses

		Cost Per General Ledger				Reclass- ification	Reclassified Total	Adjust- ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					5	6
		1	2	3	4						
	Ancillary Expense										
	E. Special Cost Centers										
43	Other (specify):*				0		0		0		
	Laboratory Expense			7,034	7,034		7,034		7,034		
	Radiology Expenses			2,785	2,785		2,785		2,785		
	Non-Allowable Expenses	79,051		46,549	125,600		125,600	(125,600)	0		
					0		0		0		
					0		0		0		
	TOTAL Other Special Cost Centers	79,051	0	56,368	135,419	0	135,419	(125,600)	9,819		

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(11,345)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,928)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(30,598)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,921)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(3,955)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,204)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(38,363)	43		24
25	Fund Raising, Advertising and Promotional	(1,748)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(510)	43		28
29	Other-Attach Schedule See Page 5A	(84,363)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (181,935)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	184,527		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 184,527		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 2,592		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Rosewood Care Ctr Galesburg

ID# 0049791

Report Period Beginning: 07/01/2013

Ending: 06/30/2014

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Eliminate Marketing Salary	\$ (79,051)	43	1
2	Miscellaneous Income Offset	(1,911)	21	2
3	Disallow Marketing Mileage Reimbursement	(3,401)	25	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				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		(84,363)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Ctr Galesburg# 0049791

Report Period Beginning:

07/01/2013

Ending:

06/30/2014

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	0	0	1,650	0	0	0	0	0	0	0	0	1,650	1
2	Food Purchase	(13,266)	0	28	0	0	0	0	0	0	0	0	(13,238)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	194	0	22	0	0	0	0	0	0	216	5
6	Maintenance	0	0	144	0	(84,591)	0	6,800	0	0	0	0	(77,647)	6
7	Other (specify):*	0	0	186	0	4,223	0	0	0	0	0	0	4,409	7
8	TOTAL General Services	(13,266)	0	2,202	0	(80,346)	0	6,800	0	0	0	0	(84,610)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	41,438	4,200	0	0	0	0	0	0	0	0	45,638	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	3,373	474	0	0	0	0	0	0	0	0	3,847	15
16	TOTAL Health Care and Programs	0	44,811	4,674	0	0	0	0	0	0	0	0	49,485	16
	C. General Administration													
17	Administrative	0	(123,976)	(79,291)	0	0	0	3,600	0	0	0	0	(199,667)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,204)	106	8,049	(1,282)	0	94,951	0	0	0	0	0	98,620	19
20	Fees, Subscriptions & Promotions	(3,955)	11	1,421	257	8	0	0	0	0	0	0	(2,258)	20
21	Clerical & General Office Expenses	(1,911)	47,326	91,145	12,467	648	430	1,101	0	0	0	0	151,206	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,675	2,750	103	1,603	62	0	0	0	0	0	6,193	24
25	Other Admin. Staff Transportation	(3,401)	2,531	1,187	250	3,489	0	0	0	0	0	0	4,056	25
26	Insurance-Prop.Liab.Malpractice	0	288	1,887	131	1,005	463	5,171	0	0	0	0	8,945	26
27	Other (specify):*	0	4,915	8,234	1,190	0	0	0	0	0	0	0	14,339	27
28	TOTAL General Administration	(12,471)	(67,124)	35,382	13,116	6,753	95,906	9,872	0	0	0	0	81,434	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(25,737)	(22,313)	42,258	13,116	(73,593)	95,906	16,672	0	0	0	0	46,309	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Ctr Galesburg# 0049791

Report Period Beginning:

07/01/2013 Ending:06/30/2014

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	0	0	6,315	0	1,083	0	78,869	0	0	0	0	86,267	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(30,598)	0	454	65	0	(187,647)	569,566	0	0	0	0	351,840	32
33	Real Estate Taxes	0	0	0	0	0	0	78,258	0	0	0	0	78,258	33
34	Rent-Facility & Grounds	0	0	5,679	0	0	0	(450,000)	0	0	0	0	(444,321)	34
35	Rent-Equipment & Vehicles	0	8,672	1,167	0	0	0	0	0	0	0	0	9,839	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(30,598)	8,672	13,615	65	1,083	(187,647)	276,693	0	0	0	0	81,883	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(125,600)	0	0	0	0	0	0	0	0	0	0	(125,600)	43
44	TOTAL Special Cost Centers	(125,600)	0	0	0	0	0	0	0	0	0	0	(125,600)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(181,935)	(13,641)	55,873	13,181	(72,510)	(91,741)	293,365	0	0	0	0	2,592	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
Bravo Services, L.L.C.	100	See Page 6 - Supplemental		See Page 6 - Supplemental		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	10 Nursing & Medical Records	\$	Bravo Nursing Home Services, Inc.	0.00%	\$ 41,438	\$ 41,438	1
2	V	15 Mgmt. Allocation of Benefits		Bravo Nursing Home Services, Inc.	0.00%	3,373	3,373	2
3	V	17 Mgmt Fee/Administrative	138,000	Bravo Nursing Home Services, Inc.	0.00%	14,024	(123,976)	3
4	V	19 Professional Services		Bravo Nursing Home Services, Inc.	0.00%	106	106	4
5	V	20 Dues, Fees, Subs & Promotions		Bravo Nursing Home Services, Inc.	0.00%	11	11	5
6	V	21 Clerical and General Office		Bravo Nursing Home Services, Inc.	0.00%	47,326	47,326	6
7	V	24 Travel and Seminar		Bravo Nursing Home Services, Inc.	0.00%	1,675	1,675	7
8	V	25 Other Admin. Staff Transport.		Bravo Nursing Home Services, Inc.	0.00%	2,531	2,531	8
9	V	26 Insurance-Prop./Liab./Malprac.		Bravo Nursing Home Services, Inc.	0.00%	288	288	9
10	V	27 Mgmt. Allocation of Benefits		Bravo Nursing Home Services, Inc.	0.00%	4,915	4,915	10
11	V	35 Rent-Equipment & Vehicles		Bravo Nursing Home Services, Inc.	0.00%	8,672	8,672	11
12	V							12
13	V							13
14	Total		\$ 138,000			\$ 124,359	\$ * (13,641)	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	<u>1</u> Dietary	\$	Midwest Administrative Services, Inc.	0.00%	\$ 1,650	\$ 1,650	15
16	V	<u>2</u> Food		Midwest Administrative Services, Inc.	0.00%	28	28	16
17	V	<u>5</u> Utilities		Midwest Administrative Services, Inc.	0.00%	194	194	17
18	V	<u>6</u> Maintenance		Midwest Administrative Services, Inc.	0.00%	144	144	18
19	V	<u>7</u> Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	186	186	19
20	V	<u>10</u> Nursing and Medical Records		Midwest Administrative Services, Inc.	0.00%	4,200	4,200	20
21	V	<u>15</u> Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	474	474	21
22	V	<u>17</u> Mgmt Fee/Administrative	81,325	Midwest Administrative Services, Inc.	0.00%	2,034	(79,291)	22
23	V	<u>19</u> Professional Services		Midwest Administrative Services, Inc.	0.00%	8,049	8,049	23
24	V	<u>20</u> Dues, Fees, Subs & Promotions		Midwest Administrative Services, Inc.	0.00%	1,421	1,421	24
25	V	<u>21</u> Clerical and General Office		Midwest Administrative Services, Inc.	0.00%	91,145	91,145	25
26	V	<u>24</u> Travel and Seminar		Midwest Administrative Services, Inc.	0.00%	2,750	2,750	26
27	V	<u>25</u> Other Admin. Staff Transport.		Midwest Administrative Services, Inc.	0.00%	1,187	1,187	27
28	V	<u>26</u> Insurance-Prop./Liab./Malprac.		Midwest Administrative Services, Inc.	0.00%	1,887	1,887	28
29	V	<u>27</u> Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	8,234	8,234	29
30	V	<u>30</u> Depreciation		Midwest Administrative Services, Inc.	0.00%	6,315	6,315	30
31	V	<u>32</u> Interest		Midwest Administrative Services, Inc.	0.00%	454	454	31
32	V	<u>34</u> Rent-Facility and Grounds		Midwest Administrative Services, Inc.	0.00%	5,679	5,679	32
33	V	<u>35</u> Rent-Equipment & Vehicles		Midwest Administrative Services, Inc.	0.00%	1,167	1,167	33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 81,325			\$ 137,198	\$ * 55,873	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 Services	\$ 1,889	Claims Administration Services, LLC	0.00%	\$ 607	\$ (1,282)	15
16	V	20 Dues, Fees, Subs & Promotions		Claims Administration Services, LLC	0.00%	257	257	16
17	V	21 Clerical and General Office		Claims Administration Services, LLC	0.00%	12,467	12,467	17
18	V	24 Travel and Seminar		Claims Administration Services, LLC	0.00%	103	103	18
19	V	25 Other Admin. Staff Transport.		Claims Administration Services, LLC	0.00%	250	250	19
20	V	26 Insurance-Prop./Liab./Malprac.		Claims Administration Services, LLC	0.00%	131	131	20
21	V	27 Mgmt. Allocation of Benefits		Claims Administration Services, LLC	0.00%	1,190	1,190	21
22	V	32 Interest		Claims Administration Services, LLC	0.00%	65	65	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		\$ 1,889			\$ 15,070	\$ * 13,181	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.	0.00%	\$ 22	\$	22	15
16	V	6 Maintenance	125,372	Senior Living Services, Inc.	0.00%	40,781		(84,591)	16
17	V	7 Mgmt. Allocation of Benefits		Senior Living Services, Inc.	0.00%	4,223		4,223	17
18	V	20 Dues, Fees, Subs & Promotions		Senior Living Services, Inc.	0.00%	8		8	18
19	V	21 Clerical and General Office		Senior Living Services, Inc.	0.00%	648		648	19
20	V	24 Travel and Seminar		Senior Living Services, Inc.	0.00%	1,603		1,603	20
21	V	25 Other Admin. Staff Transport.		Senior Living Services, Inc.	0.00%	3,489		3,489	21
22	V	26 Insurance-Prop./Liab./Malprac.		Senior Living Services, Inc.	0.00%	1,005		1,005	22
23	V	30 Depreciation		Senior Living Services, Inc.	0.00%	1,083		1,083	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		\$ 125,372			\$ 52,862	\$ *	(72,510)	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 Services	\$	Bravo Holding Company	0.00%	\$ 94,951	\$ 94,951
16	V	21 Clerical and General Office		Bravo Holding Company	0.00%	430	430
17	V	24 Travel and Seminar		Bravo Holding Company	0.00%	62	62
18	V	26 Insurance-Prop./Liab./Malprac.		Bravo Holding Company	0.00%	463	463
19	V	32 Interest	203,596	Bravo Holding Company	0.00%	15,949	(187,647)
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 203,596			\$ 111,855	\$ * (91,741)

* 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	6 Repairs and Maintenance	\$	Galesburg Real Estate, Inc.	0.00%	\$ 6,800	\$	6,800	15
16	V	17 Administrative		Galesburg Real Estate, Inc.	0.00%	3,600		3,600	16
17	V	21 Clerical and General Office		Galesburg Real Estate, Inc.	0.00%	1,101		1,101	17
18	V	26 Insurance-Prop./Liab./Malprac.		Galesburg Real Estate, Inc.	0.00%	5,171		5,171	18
19	V	30 Depreciation		Galesburg Real Estate, Inc.	0.00%	78,869		78,869	19
20	V	32 Interest		Galesburg Real Estate, Inc.	0.00%	569,566		569,566	20
21	V	33 Real Estate Taxes		Galesburg Real Estate, Inc.	0.00%	78,258		78,258	21
22	V	34 Rent-Facility and Grounds	450,000	Galesburg Real Estate, Inc.	0.00%			(450,000)	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		\$ 450,000			\$ 743,365	\$ *	293,365	39

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

Facility Name & ID Number

Rosewood Care Ctr Galesburg

0049791

Report Period Beginning:

07/01/2013

Ending:

06/30/2014

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			Bravo Care of East Alton, Inc.	Alton, IL	Bravo Care of Wood		Supportive Living	2
3			Bravo Care of East Peoria, Inc.	East Peoria, IL	River, Inc.	Wood River, IL	Facility	3
4			Bravo Care of Edwardsville, Inc.	Edwardsville, IL	Bravo Nursing Home			4
5			Bravo Care of Elgin, Inc.	Elgin, IL	Services, Inc.	St. Louis, MO	Management Co.	5
6			Bravo Care of Inverness, Inc.	Inverness, IL	Bravo Holding			6
7			Bravo Care of Joliet, Inc.	Joliet, IL	Company, Inc.	St. Louis, MO	Holding Co.	7
8			Bravo Care of Moline, Inc.	Moline, IL	Senior Living		Building Services	8
9			Bravo Care of Northbrook, Inc.	Northbrook, IL	Services, Inc.	St. Louis, MO	Company	9
10			Bravo Care of Peoria, Inc.	Peoria, IL	Bravo Team		Human Resources	10
11			Bravo Care of Rockford, Inc.	Rockford, IL	Health, Inc.	St. Louis, MO	Company	11
12			Bravo Care of St. Charles, Inc.	St. Charles, IL	Claims Administration		Legal Services	12
13			Bravo Care of St. Louis, Inc.	St. Louis, MO	Services, LLC	St. Louis, MO		13
14					Galesburg Real			14
15					Estate, nc.	Galesburg, IL	Lessor	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 Ctr Galesburg # 0049791 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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	Michael Brady	President (Note 1)	Administrative	0.00	96,431	3.39	6.78	Salary	\$ 7,012	L17, C7	1
2	Mark Yampol	CEO (Note 2)	Administrative	0.00	27,968	3.39	6.78	Salary	2,034	L17, C7	2
3											3
4											4
5											5
6											6
7											7
8											8
9	Note 1: Michael Brady was the President of Bravo Nursing Home Services, Inc. from 7/1/13 to 12/30/13. When the stock of the companies were sold, Mr. Brady became										9
10	Director of Administrative Services and was no longer President. The wages above reflect only the period of time from when he was President.										10
11	Note 2: Mark Yampol is the CEO of Midwest Administrative Services, Inc. beginning 12/31/13, when the stock of the companies were purchased.										11
12	The wages above reflect only the period of time from 12/31/13 thru 6/30/14.										12
13								TOTAL	\$ 9,046		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 Ctr Galesburg

0049791 Report Period Beginning: 07/01/2013

Ending: 6/30/2014

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Bravo Nursing Home Service
 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

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

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	Nursing & Medical Records	WeightedCensus	497,328	15	611,304	611,304	33,712	\$ 41,438	1
2	15	Mgmt. Allocation of Benefits	WeightedCensus	497,328	15	49,766		33,712	3,373	2
3	17	Administrative	WeightedCensus	497,328	15	206,886	206,886	33,712	14,024	3
4	19	Professional Services	WeightedCensus	497,328	15	1,560		33,712	106	4
5	20	Dues, Fees, Subs & Promotions	WeightedCensus	497,328	15	155		33,712	11	5
6	21	Clerical and General Office	WeightedCensus	497,328	15	698,165	683,784	33,712	47,326	6
7	24	Travel and Seminar	WeightedCensus	497,328	15	24,702		33,712	1,675	7
8	25	Other Admin. Staff Transport.	WeightedCensus	497,328	15	37,333		33,712	2,531	8
9	26	Insurance-Prop./Liab./Malprac.	WeightedCensus	497,328	15	4,250		33,712	288	9
10	27	Mgmt. Allocation of Benefits	WeightedCensus	497,328	15	72,507		33,712	4,915	10
11	35	Rent-Equipment & Vehicles	WeightedCensus	497,328	15	127,935		33,712	8,672	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21		** - Please note that the 15 subunits that are being allocated among include a facility in Swansea, IL. This facility was managed from								21
22		7/1/13 thru 3/31/14. The facility units used for the Swansea facility was based on the census through 3/31/14. The Swansea facility								22
23		is not a related party.								23
24										24
25	TOTALS					\$ 1,834,563	\$ 1,501,974		\$ 124,359	25

Facility Name & ID Number Rosewood Care Ctr Galesburg

0049791 Report Period Beginning: 07/01/2013

Ending: 6/30/2014

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization 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

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

1	2	3	4	5**	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	497,328	15	24,339	24,339	33,712	\$ 1,650	1	
2	2	Food	497,328	15	417		33,712	28	2	
3	5	Utilities	497,328	15	2,858		33,712	194	3	
4	6	Maintenance	497,328	15	2,125		33,712	144	4	
5	7	Mgmt. Allocation of Benefits	497,328	15	2,750		33,712	186	5	
6	10	Nursing and Medical Records	497,328	15	61,958	61,958	33,712	4,200	6	
7	15	Mgmt. Allocation of Benefits	497,328	15	6,997		33,712	474	7	
8	17	Administrative	497,328	15	30,003	30,003	33,712	2,034	8	
9	19	Professional Services	497,328	15	118,742		33,712	8,049	9	
10	20	Dues, Fees, Subs & Promotions	497,328	15	20,968		33,712	1,421	10	
11	21	Clerical and General Office	497,328	15	1,344,593	1,045,674	33,712	91,145	11	
12	24	Travel and Seminar	497,328	15	40,571		33,712	2,750	12	
13	25	Other Admin. Staff Transport.	497,328	15	17,516		33,712	1,187	13	
14	26	Insurance-Prop./Liab./Malprac.	497,328	15	27,838		33,712	1,887	14	
15	27	Mgmt. Allocation of Benefits	497,328	15	121,473		33,712	8,234	15	
16	30	Depreciation	497,328	15	93,160		33,712	6,315	16	
17	32	Interest	497,328	15	6,702		33,712	454	17	
18	34	Rent-Facility and Grounds	497,328	15	83,780		33,712	5,679	18	
19	35	Rent-Equipment & Vehicles	497,328	15	17,213		33,712	1,167	19	
20									20	
21		** - Please note that the 15 subunits that are being allocated among include a facility in Swansea, IL. This facility was managed from 7/1/13 thru 3/31/14. The facility units used for the Swansea facility was based on the census through 3/31/14. The Swansea facility is not a related party.								21
22										22
23										23
24										24
25	TOTALS				\$ 2,024,003	\$ 1,161,974		\$ 137,198	25	

Facility Name & ID Number Rosewood Care Ctr Galesburg

0049791 Report Period Beginning: 07/01/2013

Ending: 6/30/2014

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization 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

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

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 Services	Weighted Census/Direct Exp 497,328	15	\$ 38,020	\$	33,712	\$ 607	1	
2	20	Dues, Fees, Subs & Promotions	Weighted Census 497,328	15	3,789		33,712	257	2	
3	21	Clerical and General Office	Weighted Census 497,328	15	183,917	183,869	33,712	12,467	3	
4	24	Travel and Seminar	Weighted Census 497,328	15	1,515		33,712	103	4	
5	25	Other Admin. Staff Transport.	Weighted Census 497,328	15	3,685		33,712	250	5	
6	26	Insurance-Prop./Liab./Malprac.	Weighted Census 497,328	15	1,930		33,712	131	6	
7	27	Mgmt. Allocation of Benefits	Weighted Census 497,328	15	17,550		33,712	1,190	7	
8	32	Interest	Weighted Census 497,328	15	957		33,712	65	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		** - Please note that the 15 subunits that are being allocated among include a facility in Swansea, IL. This facility was managed from 7/1/13 thru 3/31/14. The facility units used for the Swansea facility was based on the census through 3/31/14. The Swansea facility is not a related party.								21
22										22
23										23
24										24
25	TOTALS					\$ 251,363	\$ 183,869		\$ 15,070	25

Facility Name & ID Number Rosewood Care Ctr Galesburg

0049791 Report Period Beginning: 07/01/2013

Ending: 6/30/2014

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization 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

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

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	Weighted Census	497,328	15	\$ 320	\$ 33,712	\$ 22	1	
2	6	Maintenance	Weighted Census/Direct Exp	497,328	15	998,295	573,323	33,712	40,781	2
3	7	Mgmt. Allocation of Benefits	Weighted Census	497,328	15	62,296	33,712	33,712	4,223	3
4	20	Dues, Fees, Subs & Promotions	Weighted Census	497,328	15	120	33,712	33,712	8	4
5	21	Clerical and General Office	Weighted Census	497,328	15	9,566	33,712	33,712	648	5
6	24	Travel and Seminar	Weighted Census	497,328	15	23,651	33,712	33,712	1,603	6
7	25	Other Admin. Staff Transport.	Weighted Census	497,328	15	51,467	33,712	33,712	3,489	7
8	26	Insurance-Prop./Liab./Malprac.	Weighted Census	497,328	15	14,825	33,712	33,712	1,005	8
9	30	Depreciation	Weighted Census	497,328	15	15,975	33,712	33,712	1,083	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21	** - Please note that the 15 subunits that are being allocated among include a facility in Swansea, IL. This facility was managed from									21
22	7/1/13 thru 3/31/14. The facility units used for the Swansea facility was based on the census through 3/31/14. The Swansea facility									22
23	is not a related party.									23
24										24
25	TOTALS					\$ 1,176,515	\$ 573,323	\$	52,862	25

Facility Name & ID Number Rosewood Care Ctr Galesburg

0049791

Report Period Beginning: 07/01/2013

Ending: 6/30/2014

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Bravo Holding Company
 Street Address 11701 Borman Drive, Suite 315
 City / State / Zip Code St. Louis, MO 63146
 Phone Number (314) 994-9070
 Fax Number (314) 994-9912

1 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 Services	Weighted Census	497,328	15	\$ 1,400,742	\$ 33,712	\$ 94,951	1
2	21	Clerical and General Office	Weighted Census	497,328	15	6,337	33,712	430	2
3	24	Travel and Seminar	Weighted Census	497,328	15	913	33,712	62	3
4	26	Insurance-Prop./Liab./Malprac.	Weighted Census	497,328	15	6,835	33,712	463	4
5	32	Interest	Weighted Census	497,328	15	235,278	33,712	15,949	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	** - Please note that the 15 subunits that are being allocated among include a facility in Swansea, IL. This facility was managed from								
22	7/1/13 thru 3/31/14. The facility units used for the Swansea facility was based on the census through 3/31/14. The Swansea facility								
23	is not a related party.								
24									24
25	TOTALS					\$ 1,650,105	\$	\$ 111,855	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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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	Mid Cap		X	Mortgage	250,000 + Int		\$ 12,000,000	\$ 12,000,000		0.1000	\$ 548,000	1				
2												2				
3												3				
4												4				
5												5				
Working Capital																
6	MidCap (Thru Allocation of		X	Revolving Line of Credit		8/1/09			12/31/14	5.0000	37,515	6				
7	Bravo Holding Co.)											7				
8												8				
9	TOTAL Facility Related						\$ 12,000,000	\$ 12,000,000			\$ 585,515	9				
B. Non-Facility Related*																
10							Less: Interest Income Offset				(30,598)	10				
11							Allocated from Mgmt Co's				519	11				
12												12				
13												13				
14	TOTAL Non-Facility Related						\$	\$			\$ (30,079)	14				
15	TOTALS (line 9+line14)						\$ 12,000,000	\$ 12,000,000			\$ 555,436	15				

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																		
1. Real Estate Tax accrual used on 2013 report.				\$	140,831	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.)	See Below			\$	142,246	2														
3. Under or (over) accrual (line 2 minus line 1).				\$	1,415	3														
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	147,956	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.				\$	149,371	7														
Real Estate Tax History:																				
Real Estate Tax Bill for Calendar Year:	2009	191,963	8	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2013 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>			FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2013 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR BHF USE ONLY																				
13	FROM R. E. TAX STATEMENT FOR 2013 \$	13																		
14	PLUS APPEAL COST FROM LINE 5 \$	14																		
15	LESS REFUND FROM LINE 6 \$	15																		
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																		
Taxes Paid-2012	2010	189,839	9																	
Taxes Paid-2013	2011	139,343	10																	
Total Taxes Paid	2012	139,437	11																	
	2013	145,055	12																	
<u>Accrual based on prior year tax bill.</u>																				
<u>Note: The real estate entity was purchased on 12/31/13, therefore the beginning accrual used above reflects the accrued real estate tax balance as of 6/30/13 in order for the worksheet to compute properly.</u>																				
<u>See explanation on Att Sch I</u>																				

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.

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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 Ctr Galesburg

0049791 Report Period Beginning:

07/01/2013 Ending:

06/30/2014

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,331 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A
 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>	<u>5 Acres</u>	<u>1987</u>	<u>\$ 182,779</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	#VALUE!		\$ 182,779	3

Facility Name & ID Number Rosewood Care Ctr Galesburg

0049791

Report Period Beginning:

07/01/2013

Ending:

06/30/2014

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	120	1987	1987	\$ 2,660,363	\$	25-40	\$ 31,846	\$ 31,846	\$ 1,811,557	4
5	60	1998	1998	2,598,716		25-40	36,309	36,309	1,219,186	5
6										6
7										7
8										8
Improvement Type**										
9	Building Improvements - Real Estate Entity									9
10										10
11	Facility Signage		1987	7,572		10			7,572	11
12	Hot Water Booster/Sinks		1987	4,606		10			4,606	12
13	Exhaust Hood & Fire Suppression System		1987	9,019		10			9,019	13
14	Carpet		1987	11,131		10			1,131	14
15	Nurse Call System & Paging System		1987	45,340		10			45,340	15
16	Seeding/Landscaping/Berm		1988	32,414		25	129	129	32,414	16
17	Nurse Call Addition		1988	1,643		10			1,643	17
18	18 Bed Addition		1989	49,460		40	618	618	30,716	18
19	Painting		1991	1,360		10			1,360	19
20	Facility Signage		1991	5,133		10			5,133	20
21	Painting		1992	1,520		10			1,520	21
22	Roof Vents		1992	6,896		40	86	86	3,836	22
23	Parking Lot Improvements		1992	5,673		25	114	114	4,973	23
24	Facility Signage		1992	1,000		10			1,000	24
25	Water Heaters		1992	3,123		10			3,123	25
26	Irrigation System		1994	7,253		25	145	145	6,093	26
27	Landscaping		1998	3,183		25	64	64	2,037	27
28	Shingle Roof Replacement		2002	102,091		40	1,276	1,276	32,116	28
29	Seal & Restripe Parking Lot		2003	14,545		25	291	291	6,351	29
30	Repair Soffit & Facia on Gables		2003	5,394		40	68	68	1,439	30
31	Air Conditioning Unit & Heat Pumps		2003	9,817		10	99	99	9,817	31
32	Boiler		2003	20,269		10	338	338	20,269	32
33	Heat Pumps		2004	2,875		10	84	84	2,875	33
34	Paint Exterior of Building		2005	2,875		40	36	36	677	34
35	Fire Alarm Panel		2005	2,647		10	133	133	2,338	35
36	Console Heat Pumps		2006	6,337		10	317	317	5,281	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 Ctr Galesburg

0049791

Report Period Beginning:

07/01/2013

Ending:

06/30/2014

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 <u>Building Improvements - Real estate Entity, continued</u>		\$	\$		\$	\$	\$	37
38								38
39 <u>Seal and Stripe Parking Lot</u>	2006	5,195		25	104	104	1,576	39
40 <u>Replace Sidewalk</u>	2007	5,778		40	72	72	963	40
41 <u>Seal and Stripe Parking Lot</u>	2008	6,245		25	125	125	1,499	41
42 <u>Shower Improvements</u>	2008	10,336		40	129	129	1,529	42
43 <u>Heat Pumps</u>	2009	4,218		10	211	211	1,968	43
44 <u>Seal and Stripe Parking Lot</u>	2010	6,975		25	140	140	1,116	44
45 <u>Generator</u>	2010	4,888		10	245	245	1,751	45
46 <u>Doors</u>	2011	14,790		10	740	740	4,067	46
47 <u>Sprinkler</u>	2012	6,753		10	338	338	1,632	47
48 <u>Sprinkler</u>	2012	3,704		40	47	47	177	48
49 <u>Boiler/Burner/Pump</u>	2013	8,358		40	105	105	209	49
50 <u>New Window Sills and Counters</u>	2013	3,710		40	47	47	93	50
51 <u>Firestopping Corridor Controls</u>	2013	5,012		40	52	52	104	51
52 <u>HVAC Improvements</u>	2014	8,156		10	204	204	408	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								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 5,716,373	\$		\$ 74,512	\$ 74,512	\$ 3,290,514	70

**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	\$ 81,217	\$ 15,255	\$ 15,255	\$	5	\$ 22,367	71
72	Current Year Purchases	3,882	1,049	1,049		5	1,049	72
73	Fully Depreciated Assets							73
74	Allocated from Mgmt Co/Real Estate Entity	1,200,230		11,755	11,755		1,168,591	74
75	TOTALS	\$ 1,285,329	\$ 16,304	\$ 28,059	\$ 11,755		\$ 1,192,007	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 7,184,481	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 16,304	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 102,571	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 86,267	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,482,521	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	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 Ctr Galesburg

0049791

Report Period Beginning: 07/01/2013

Ending: 06/30/2014

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Galesburg Real Estate, Inc.

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:	<u>1997</u>	<u>120</u>	<u>5/1/08</u>	\$ <u>455,679</u>	<u>5</u>	<u>Unlimited</u>	3
4	Additions	<u>1998</u>	<u>60</u>					4
5								5
6								6
7	TOTAL		<u>180</u>		\$ <u>455,679</u>			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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 N/A.

N/A

9. Option to Buy: YES NO Terms: N/A *

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: \$ 24,532 Description: Medical Equipment Rental \$11,887; Offsite Storage \$2,806, Home Office Allocation - \$9,839

(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	<u>Patient</u>	<u>2012 Ford E-350 Van</u>	\$ <u>1,356.67</u>	\$ <u>16,280</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>1,356.67</u>	\$ <u>16,280</u>	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 Ctr Galesburg # 0049791 Report Period Beginning: 07/01/2013 Ending: 06/30/2014
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	3,924	\$ 156,208	\$	3,924	\$ 156,208	1	
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		336	20,229		336	20,229	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		4,346	171,392	666	4,346	172,058	4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy	39(2)	# of prescrpts				118,518		118,518	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify):									13	
14	TOTAL			\$	8,606	\$ 347,829	\$ 119,184	8,606	\$ 467,013	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.

Facility Name & ID Number Rosewood Care Ctr Galesburg# 0049791Report Period Beginning: 07/01/2013

Ending:

06/30/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2014

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 6,091	\$ 21,728	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>50,366</u>)	755,929	755,929	3
4	Supply Inventory (priced at <u>Cost</u>)	4,059	4,059	4
5	Short-Term Investments			5
6	Prepaid Insurance	15,321	18,629	6
7	Other Prepaid Expenses	5,152	5,152	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 786,552	\$ 805,497	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		182,779	13
14	Buildings, at Historical Cost		5,259,079	14
15	Leasehold Improvements, at Historical Cost		457,294	15
16	Equipment, at Historical Cost	85,099	1,285,329	16
17	Accumulated Depreciation (book methods)	(23,416)	(4,482,521)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		1,250,000	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Deposits</u>	2,000	2,000	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 63,683	\$ 3,953,960	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 850,235	\$ 4,759,457	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 312,979	\$ 312,979	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	301,759	301,759	30
31	Accrued Taxes Payable (excluding real estate taxes)	22,046	22,046	31
32	Accrued Real Estate Taxes(Sch.IX-B)		147,956	32
33	Accrued Interest Payable		38,000	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	14,235	35,105	35
	Other Current Liabilities(specify):			
36	<u>Accrued Expenses</u>	150,210	153,710	36
37	<u>Accrued Rent</u>	568,584		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,369,813	\$ 1,011,555	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		12,000,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Due to Bravo Holding Company</u>	3,860,750	5,582,383	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,860,750	\$ 17,582,383	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,230,563	\$ 18,593,938	46
47	TOTAL EQUITY(page 18, line 24)	\$ (4,380,328)	\$ (13,834,481)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 850,235	\$ 4,759,457	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,259,299)	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,259,298)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,121,030)	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)	\$ (1,121,030)	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)	\$ (4,380,328)	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	\$ 6,587,820	1	
2	Discounts and Allowances for all Levels	(919,235)	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,668,585	3	
B. Ancillary Revenue				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	133,700	6	
7	Oxygen		7	
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 133,700	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	2,700	13	
14	Non-Patient Meals	10,053	14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	
17	Sale of Drugs		17	
18	Sale of Supplies to Non-Patients		18	
19	Laboratory		19	
20	Radiology and X-Ray		20	
21	Other Medical Services	36,027	21	
22	Laundry		22	
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 48,780	23	
D. Non-Operating Revenue				
24	Contributions		24	
25	Interest and Other Investment Income***	30,598	25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 30,598	26	
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)		27	
28	<u>See Attached Schedule</u>	5,124	28	
28a			28a	
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,124	29	
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,886,787	30	

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	1,292,833	31	
32	Health Care	2,913,018	32	
33	General Administration	1,038,777	33	
B. Capital Expense				
34	Ownership	1,221,986	34	
C. Ancillary Expense				
35	Special Cost Centers	253,937	35	
36	Provider Participation Fee	287,266	36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,007,817	40	
41	Income before Income Taxes (line 30 minus line 40)**	(1,121,030)	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,121,030)	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,024,128	44
45	Private Pay - Net Inpatient Revenue	2,069,795	45
46	Medicare - Net Inpatient Revenue	1,287,551	46
47	Other-(specify) <u>Insurance</u>	287,111	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,668,585	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.

Rosewood Care Ctr Galesburg

Period Beginning 07/01/2013
Period End 06/30/2014

Schedule 19A

Other Revenue:

Vending Income	1,292
Vendor Discount	1,921
Miscellaneous	1,911
	<hr/>
Total Other Revenue	<u>5,124</u>

Facility Name & ID Number Rosewood Care Ctr Galesburg

0049791

Report Period Beginning: 07/01/2013

Ending: 06/30/2014

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	2,095	2,223	\$ 61,841	\$ 27.82	1
2	Assistant Director of Nursing	1,433	1,481	34,767	23.48	2
3	Registered Nurses	10,882	11,606	293,222	25.26	3
4	Licensed Practical Nurses	33,361	35,973	639,241	17.77	4
5	CNAs & Orderlies	95,647	100,868	988,459	9.80	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,221	2,545	26,965	10.60	8
9	Activity Director	2,080	2,189	23,200	10.60	9
10	Activity Assistants	3,052	3,142	26,327	8.38	10
11	Social Service Workers	4,349	4,619	57,022	12.35	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,552	25,630	248,723	9.70	15
16	Dishwashers					16
17	Maintenance Workers	2,106	2,286	30,968	13.55	17
18	Housekeepers	20,451	22,059	206,913	9.38	18
19	Laundry	6,283	6,699	58,314	8.70	19
20	Administrator	2,080	2,200	86,886	39.49	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,041	9,782	107,745	11.01	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	2,721	2,952	31,759	10.76	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Sch 20A</u>	12,444	13,762	256,240	18.62	33
34	TOTAL (lines 1 - 33)	233,798	250,016	\$ 3,178,592 *	\$ 12.71	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 7,686	L1, C3	35
36	Medical Director	Monthly	9,875	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,943	L10, C3	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	2,400	L11, C3	44
45	Social Service Consultant	Monthly	2,600	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 30,504		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	N/A	\$	50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)		\$	53

Rosewood Care Ctr Galesburg

Period Beginning 07/01/2013
Period End 06/30/2014

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Nurse	2,153	2,259	46,510	20.59
Case Manager	1,886	2,196	53,083	24.17
Rehabilitation Nurse	2,185	2,404	41,919	17.44
Ward Clerk	1,980	2,121	35,677	16.82
Marketing	4,240	4,782	79,051	16.53
TOTAL	<u>12,444</u>	<u>13,762</u>	<u>256,240</u>	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Jeff Howd	Administrator	0	\$ 86,886	Workers' Compensation Insurance	\$ 85,561	IDPH License Fee	\$ 3,980	
				Unemployment Compensation Insurance	37,065	Advertising: Employee Recruitment	3,072	
				FICA Taxes	237,888	Health Care Worker Background Check		
				Employee Health Insurance	39,924	(Indicate # of checks performed)	1,621	
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Misc. Dues/Subscriptions/Fees	836	
				Employee Relations	2,988	Rosewood License Fee	1,500	
				Employee Uniforms	1,243	IHCA Dues	6,348	
				Employee Physicals	2,142	Misc. Licenses & Fees	874	
				Employee Drug Tests	250	Home Office Allocation	1,697	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		
					\$ 86,886		\$ 19,928	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description				Description			Description	
Amount				Line #			Amount	
Mgmt Fees-Bravo Nursing Home Svc-See Page 6, Elimon P 3, C 7				N/A			Out-of-State Travel	
\$ 138,000							\$	
Mgmt Fees-Midwest Admin Svc-See Page 6, Elimon P 3, C 7								
from 1/1/14-6/30/14 (post-acquisition)							In-State Travel	
77,725							Home Office Allocation	
							6,193	
TOTAL (agree to Schedule V, line 17, col. 3)				TOTAL			Seminar Expense	
215,725							245	
(Attach a copy of any management service agreement)							Entertainment Expense	
							()	
C. Professional Services							TOTAL (agree to Sch. V, line 24, col. 8)	
Vendor/Payee							\$ 6,438	
Type								
Amount								
Hochschild, Bloom & Company								
Accountant/Consultant								
3,394								
Midwest Administrative Services								
Administrative/Bookkeeping								
77,227								
Claims Administration Services, Inc.								
Related Party Legal Fees								
1,889								
Daniel Maher								
Legal Fees								
4,052								
Heyl, Royster, Voelker & Allen								
Legal Fees								
8,842								
Healthcare Horizons								
Healthcare Consultant								
1,135								
Register Mail								
Public Notice								
68								
Senior Care Capital								
Loan Fees								
7,500								
US Managed Care Services								
Managed Care Consultant								
200								
TOTAL (agree to Schedule V, line 19, column 3)								
104,307								
(For legal fee disclosure, see page 39 of instructions)								

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2	N/A											
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Rosewood Care Ctr Galesburg# 0049791Report Period Beginning: 07/01/2013 Ending: 06/30/2014**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. 6,348 IHCA
- (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? 5 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 48,647 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. \$ 287,266
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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 11,345
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.