

		FOR BHF USE					

LL1

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: 0049791

Facility Name: Rosewood Care Center Of Galesburg

Address: 1250 W. Carl Sandburg Drive Galesburg 61401
Number City Zip Code

County: Knox

Telephone Number: (309) 344-5400 Fax # (309) 344-7347

HFS ID Number:

Date of Initial License for Current Owners: 5/1/2008

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda Telephone Number: 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			

Facility Name & ID Number Rosewood Care Center Of Galesburg# 0049791 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>180</u>	Skilled (SNF)	<u>180</u>	<u>65,880</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>180</u>	TOTALS	<u>180</u>	<u>65,880</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>19,469</u>	<u>6,899</u>	<u>3,853</u>	<u>30,221</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>19,469</u>	<u>6,899</u>	<u>3,853</u>	<u>30,221</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 45.87%

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)

None

F. Does the facility maintain a daily midnight census?

YesG. 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 5/1/2008

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

YES ☒Date 5/1/2008NO ☐

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

2,956Medicare Intermediary Novitas Solutions, Inc.

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 6/30/2016 Fiscal Year: 6/30/2016

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

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 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	33,242	1,643	348,942	383,827		383,827	424	384,251			1
2	Food Purchase		294,870		294,870		294,870	(13,742)	281,128			2
3	Housekeeping		13,028	221,524	234,552		234,552		234,552			3
4	Laundry		539	147,683	148,222		148,222		148,222			4
5	Heat and Other Utilities			151,989	151,989		151,989	(6,919)	145,070			5
6	Maintenance	31,605	5,004	269,821	306,430		306,430	(40,334)	266,096			6
7	Other (specify):*							4,124	4,124			7
8	TOTAL General Services	64,847	315,084	1,139,959	1,519,890		1,519,890	(56,447)	1,463,443			8
	B. Health Care and Programs											
9	Medical Director			13,863	13,863		13,863		13,863			9
10	Nursing and Medical Records	1,745,274	189,063	37,172	1,971,509		1,971,509	26,921	1,998,430			10
10a	Therapy	57,441	975		58,416		58,416		58,416			10a
11	Activities	50,815	3,465	3,000	57,280		57,280		57,280			11
12	Social Services	59,189		3,000	62,189		62,189		62,189			12
13	CNA Training											13
14	Program Transportation			1,340	1,340		1,340		1,340			14
15	Other (specify):*							2,637	2,637			15
16	TOTAL Health Care and Programs	1,912,719	193,503	58,375	2,164,597		2,164,597	29,558	2,194,155			16
	C. General Administration											
17	Administrative	87,242		281,788	369,030		369,030	(233,613)	135,417			17
18	Directors Fees											18
19	Professional Services			100,868	100,868		100,868	17,539	118,407			19
20	Dues, Fees, Subscriptions & Promotions			14,553	14,553		14,553	(1,436)	13,117			20
21	Clerical & General Office Expenses	100,201	22,763	323,819	446,783		446,783	(136,378)	310,405			21
22	Employee Benefits & Payroll Taxes			318,568	318,568		318,568		318,568			22
23	Inservice Training & Education											23
24	Travel and Seminar			640	640		640	859	1,499			24
25	Other Admin. Staff Transportation			2,881	2,881		2,881	8,746	11,627			25
26	Insurance-Prop.Liab.Malpractice			94,288	94,288		94,288	19,761	114,049			26
27	Other (specify):*							21,010	21,010			27
28	TOTAL General Administration	187,443	22,763	1,137,405	1,347,611		1,347,611	(303,512)	1,044,099			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,165,009	531,350	2,335,739	5,032,098		5,032,098	(330,400)	4,701,698			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			17,020	17,020		17,020	173,757	190,777			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			308,973	308,973		308,973	1,665,650	1,974,623			32
33	Real Estate Taxes							151,267	151,267			33
34	Rent-Facility & Grounds			903,864	903,864		903,864	(886,548)	17,316			34
35	Rent-Equipment & Vehicles			19,840	19,840		19,840	(19,817)	23			35
36	Other (specify):*			46,742	46,742		46,742	(46,742)	(0)			36
37	TOTAL Ownership			1,296,439	1,296,439		1,296,439	1,037,567	2,334,006			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		108,591	418,176	526,767		526,767		526,767			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			259,757	259,757		259,757		259,757			42
43	Other (specify):*	58,345		4,926	63,271		63,271	(63,271)				43
44	TOTAL Special Cost Centers	58,345	108,591	682,859	849,795		849,795	(63,271)	786,524			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,223,354	639,941	4,315,037	7,178,332		7,178,332	643,896	7,822,228			45

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

	1	2	3	
	Amount	Refer-ence	BHF USE ONLY	
NON-ALLOWABLE EXPENSES				
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(3,793)	02		4
5 Telephone, TV & Radio in Resident Rooms	(7,263)	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	683	30		9
10 Interest and Other Investment Income				10
11 Discounts, Allowances, Rebates & Refunds	(8,543)	02		11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax	(673)	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	(47)	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	(264,920)	21		24
25 Fund Raising, Advertising and Promotional				25
Income Taxes and Illinois Personal				
26 Property Replacement Tax				26
27 CNA Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule	(406,324)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (690,880)		\$	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	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
Amortization of Organization & Pre-Operating Expense			
33			33
Adjustments for Related Organization			
34 Costs (Schedule VII)	1,334,776		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ 1,334,776		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ 643,896		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			\$		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

Rosewood Care Center Of GalesburgID# 0049791Report Period Beginning: 07/01/15Ending: 06/30/16

NON-ALLOWABLE EXPENSES		Sch. V Line	
	Amount	Reference	
1	Marketing Salary	\$ (56,995)	43 1
2	Resident Reimbursement	(45)	10 2
3	Bank Charges	(3,369)	21 3
4	Vending Income	(733)	02 4
5	Miscellaneous Income	(3,318)	21 5
6	MidCap Line of Credit Fees	(46,742)	36 6
7	Marketing Bonus	(1,350)	43 7
8	Vendor Late Charges	(6,981)	21 8
9	Bldg Co - MidCap Line of Credit Fees	(23,095)	36 9
10	Bldg Co - Vendor Late Charges	(233,089)	21 10
11	PAC Dues	(3,882)	20 11
12	Capitalized R&M	(13,653)	06 12
13	Bldg Co - Audit Fees	(4,000)	19 13
14	Marketing Expense	(2,712)	43 14
15	Marketing Travel	(2,214)	43 15
16	Bldg Co - Gain/Loss on Sale of Asset	(4,069)	36 16
17	Non Allowable Legal	(77)	19 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	(406,324)	49

ID#

0049791

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 Galesburg # 0049791 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				424								424	1
2	Food Purchase	(13,742)											(13,742)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(7,263)		145			200						(6,919)	5
6	Maintenance	(13,653)	3,000	88			(29,769)						(40,334)	6
7	Other (specify):*				45		4,080						4,124	7
8	TOTAL General Services	(34,658)	3,000	232	468		(25,490)						(56,447)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(45)			26,966								26,921	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				2,637								2,637	15
16	TOTAL Health Care and Programs	(45)			29,603								29,558	16
	C. General Administration													
17	Administrative			(143,788)	(96,339)	6,514							(233,613)	17
18	Directors Fees													18
19	Professional Services	(4,077)	4,000	105	76	17,338	97						17,539	19
20	Fees, Subscriptions & Promotions	(3,882)		2,129	2	222	93						(1,436)	20
21	Clerical & General Office Expenses	(511,724)	240,289	133,982	425	300	351						(136,378)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			437	154	268							859	24
25	Other Admin. Staff Transportation			2,211	2,795	1,354	2,385						8,746	25
26	Insurance-Prop.Liab.Malpractice		15,127	3,833			801						19,761	26
27	Other (specify):*			17,658	3,352								21,010	27
28	TOTAL General Administration	(519,684)	259,416	16,566	(89,535)	25,997	3,727						(303,512)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(554,386)	262,416	16,799	(59,463)	25,997	(21,763)						(330,400)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	683	157,715	14,465			894						173,757	30
31	Amortization of Pre-Op. & Org.													31
32	Interest		1,650,237	16,553		(1,140)							1,665,650	32
33	Real Estate Taxes		151,267										151,267	33
34	Rent-Facility & Grounds		(900,000)	13,452									(886,548)	34
35	Rent-Equipment & Vehicles			(19,840)	9	6	9						(19,817)	35
36	Other (specify):*	(73,906)	27,164										(46,742)	36
37	TOTAL Ownership	(73,223)	1,086,383	24,629	9	(1,134)	903						1,037,567	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):*	(63,271)											(63,271)	43
44	TOTAL Special Cost Centers	(63,271)											(63,271)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(690,880)	1,348,799	41,428	(59,454)	24,863	(20,860)						643,896	45

Facility Name & ID Number Rosewood Care Center Of Galesburg# 0049791

Report Period Beginning:

07/01/15

Ending:

06/30/16

VII. RELATED PARTIES

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

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

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



YES



NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	\$ 900,000	Galesburg Real Estate, LLC		\$	(900,000)	1
2	V	36	Gain/Loss on Asset Sale		Galesburg Real Estate, LLC		4,069	4,069	2
3	V	19	Audit Fees		Galesburg Real Estate, LLC		4,000	4,000	3
4	V	06	Purchased Repairs		Galesburg Real Estate, LLC		3,000	3,000	4
5	V	32	Interest Expense - Bank		Galesburg Real Estate, LLC		1,253,542	1,253,542	5
6	V	32	Interest Expense - MidCap		Galesburg Real Estate, LLC		25,971	25,971	6
7	V	33	Real Estate Tax		Galesburg Real Estate, LLC		151,267	151,267	7
8	V	32	Interest Expense - Bhold		Galesburg Real Estate, LLC		370,724	370,724	8
9	V	30	Depreciation		Galesburg Real Estate, LLC		157,715	157,715	9
10	V	36	MidCap Line of Credit Fees		Galesburg Real Estate, LLC		23,095	23,095	10
11	V	21	Base Admin Fee (P. 6A)		Galesburg Real Estate, LLC		7,200	7,200	11
12	V	26	Insurance Expense - Property		Galesburg Real Estate, LLC		15,127	15,127	12
13	V	21	Vendor Late Charges		Galesburg Real Estate, LLC		233,089	233,089	13
14	Total			\$ 900,000			\$ 2,248,799	\$ * 1,348,799	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%	\$ 145	\$ 145	15
16	V	6 MAINTENANCE EXPENSE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	88	88	16
17	V	19 PROFESSIONAL FEES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	105	105	17
18	V	20 DUES, SUBSCRIPTIONS, LICENSES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	2,129	2,129	18
19	V	21 OFFICE SALARIES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	111,178	111,178	19
20	V	21 OFFICE EXPENSES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	30,004	30,004	20
21	V	24 SEMINAR		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	437	437	21
22	V	25 TRAVEL EXPENSE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	2,211	2,211	22
23	V	26 INSURANCE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	3,833	3,833	23
24	V	27 EMPLOYEE BENEFITS		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	17,658	17,658	24
25	V	30 DEPRECIATION		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	14,465	14,465	25
26	V	32 INTEREST		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	16,553	16,553	26
27	V	34 BUILDING RENT		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	13,452	13,452	27
28	V							28
29	V	17 ADMINISTRATIVE FEE	143,788	MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%		(143,788)	29
30	V	21 ADMINISTRATIVE FEE (BLDG CO)	7,200	MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%		(7,200)	30
31	V	35 VEHICLE LEASE	19,840	MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%		(19,840)	31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 170,828			\$ 212,256	\$ * 41,428	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	1 DIETARY SALARY	\$	BRAVO NURSING HOME SERVICES, INC.	100.00%	\$ 424	\$ 424
16	V	7 DIETARY BENEFITS		BRAVO NURSING HOME SERVICES, INC.	100.00%	45	45
17	V	10 CORPORATE RN SALARIES		BRAVO NURSING HOME SERVICES, INC.	100.00%	26,966	26,966
18	V	15 CORPORATE RN SALARIES BENEFITS		BRAVO NURSING HOME SERVICES, INC.	100.00%	2,637	2,637
19	V	17 ADMINISTRATIVE SALARIES		BRAVO NURSING HOME SERVICES, INC.	100.00%	41,661	41,661
20	V	19 PROFESSIONAL FEES		BRAVO NURSING HOME SERVICES, INC.	100.00%	76	76
21	V	20 DUES & SUBSCRIPTIONS		BRAVO NURSING HOME SERVICES, INC.	100.00%	2	2
22	V	21 OFFICE EXPENSES		BRAVO NURSING HOME SERVICES, INC.	100.00%	425	425
23	V	24 SEMINAR & LODGING EXPENSE		BRAVO NURSING HOME SERVICES, INC.	100.00%	154	154
24	V	25 AUTO EXPENSE		BRAVO NURSING HOME SERVICES, INC.	100.00%	2,795	2,795
25	V	27 ADMINISTRATIVE & OFFICE BENEFITS		BRAVO NURSING HOME SERVICES, INC.	100.00%	3,352	3,352
26	V	35 AUTO LEASE		BRAVO NURSING HOME SERVICES, INC.	100.00%	9	9
27	V						
28	V	17 ADMINISTRATIVE FEE	138,000	BRAVO NURSING HOME SERVICES, INC.	100.00%		(138,000)
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 138,000			\$ 78,546	\$ * (59,454)

* 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%	\$ 6,514	\$ 6,514	15
16	V	19 PROFESSIONAL FEES		BRAVO HOLDING COMPANY	100.00%	17,338	17,338	16
17	V	20 DUES & SUBSCRIPTIONS		BRAVO HOLDING COMPANY	100.00%	222	222	17
18	V	21 OFFICE EXPENSE		BRAVO HOLDING COMPANY	100.00%	300	300	18
19	V	24 SEMINAR EXPENSE		BRAVO HOLDING COMPANY	100.00%	268	268	19
20	V	25 AUTO & TRAVEL EXPENSE		BRAVO HOLDING COMPANY	100.00%	1,354	1,354	20
21	V	32 INTEREST		BRAVO HOLDING COMPANY	100.00%	(1,140)	(1,140)	21
22	V	35 AUTO RENTAL		BRAVO HOLDING COMPANY	100.00%	6	6	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		\$			\$ 24,863	\$ * 24,863	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%	\$ 200	\$ 200
16	V	6 MAINTENANCE SALARY		SENIOR LIVING SERVICES, INC.	100.00%	28,774	28,774
17	V	6 MAINTENANCE EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	2,920	2,920
18	V	7 MAINTENANCE BENEFITS		SENIOR LIVING SERVICES, INC.	100.00%	4,080	4,080
19	V	19 PROFESSIONAL FEES		SENIOR LIVING SERVICES, INC.	100.00%	97	97
20	V	20 LICENSES		SENIOR LIVING SERVICES, INC.	100.00%	93	93
21	V	21 OFFICE EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	351	351
22	V	25 AUTO / TRAVEL EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	2,385	2,385
23	V	26 INSURANCE		SENIOR LIVING SERVICES, INC.	100.00%	801	801
24	V	30 DEPRECIATION		SENIOR LIVING SERVICES, INC.	100.00%	894	894
25	V	35 AUTO LEASE		SENIOR LIVING SERVICES, INC.	100.00%	9	9
26	V	6 MAINTENANCE SUPPLIES		SENIOR LIVING SERVICES, INC.	100.00%	17	17
27	V						
28	V	6 MAINTENANCE SERVICES	61,480	SENIOR LIVING SERVICES, INC.	100.00%		(61,480)
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 61,480			\$ 40,620	\$ * (20,860)

* 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 (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 East Alton, Inc.	Alton, IL	Northbrook Real Estate, LLC		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 Northbrook, Inc.	Northbrook, IL	Bravo Team Health, Inc.	St. Louis, MO	Human Resources	5
6			Bravo Care of Inverness, Inc.	Inverness, IL	Claims Administration Services, LI	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, I	St. Louis, MO	Administration	8
9			Bravo Care of Peoria, Inc.	Peoria, IL	Bravo Care of Wood River, Inc.	Wood River, IL	Supportive Living Facility	9
10			Bravo Care of Rockford, Inc.	Rockford, IL	Rosewood Home Health Services, I	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	Mark Yampol	CEO	Administrative		See Attached	1.3	6.50%	Alloc. Fees	\$ 6,514	17-07	1
2	Hillel Yampol	Owner	Administrative	50.00%	See Attached	1.3	6.50%	Alloc. Salary	1,478	17-07	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	\$ 7,992		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Rosewood Care Center Of Galesburg# 0049791

Report Period Beginning:

07/01/15Ending: 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 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 Galesburg# 0049791

Report Period Beginning:

07/01/15Ending: 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 MIDWEST ADMINISTRATIVE SERVICES, INC.
 Street Address 11701 BORMAN DRIVE, SUITE 315
 City / State / Zip Code ST. LOUIS, MO 63146
 Phone Number (314) 994-9070
 Fax Number (314) 994-9912

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PAT. DAYS	463,927	14	\$ 2,224	\$ 30,221	\$ 145	1
2	6	MAINTENANCE EXPENSE	PAT. DAYS	463,927	14	1,345	30,221	88	2
3	19	PROFESSIONAL FEES	PAT. DAYS	463,927	14	1,614	30,221	105	3
4	20	DUES, SUBSCRIPTIONS, LICENSES	PAT. DAYS	463,927	14	32,685	30,221	2,129	4
5	21	OFFICE SALARIES	PAT. DAYS	463,927	14	1,706,712	1,706,712	111,178	5
6	21	OFFICE EXPENSES	PAT. DAYS	463,927	14	460,588	30,221	30,004	6
7	24	SEMINAR	PAT. DAYS	463,927	14	6,706	30,221	437	7
8	25	TRAVEL EXPENSE	PAT. DAYS	463,927	14	33,946	30,221	2,211	8
9	26	INSURANCE	PAT. DAYS	463,927	14	58,834	30,221	3,833	9
10	27	EMPLOYEE BENEFITS	PAT. DAYS	463,927	14	271,068	30,221	17,658	10
11	30	DEPRECIATION	PAT. DAYS	463,927	14	222,055	30,221	14,465	11
12	32	INTEREST	PAT. DAYS	463,927	14	254,102	30,221	16,553	12
13	34	BUILDING RENT	PAT. DAYS	463,927	14	206,500	30,221	13,452	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	\$ 212,258	25

Facility Name & ID Number **Rosewood Care Center Of Galesburg**# **0049791**

Report Period Beginning:

07/01/15Ending: **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 **BRAVO NURSING HOME SERVICES, INC.**
 Street Address **11701 BORMAN DRIVE, SUITE 315**
 City / State / Zip Code **ST. LOUIS, MO 63146**
 Phone Number **(314) 994-9070**
 Fax Number **(314) 994-9912**

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARY	PAT. DAYS	463,927	14	\$ 6,505	\$ 6,505	30,221	\$ 424	1
2	7	DIETARY BENEFITS	PAT. DAYS	463,927	14	687		30,221	45	2
3	10	CORPORATE RN SALARIES	PAT. DAYS	463,927	14	413,960	413,960	30,221	26,966	3
4	15	CORPORATE RN SALARIES B	PAT. DAYS	463,927	14	40,484		30,221	2,637	4
5	17	ADMINISTRATIVE SALARIES	PAT. DAYS	463,927	14	639,544	639,544	30,221	41,661	5
6	19	PROFESSIONAL FEES	PAT. DAYS	463,927	14	1,170		30,221	76	6
7	20	DUES & SUBSCRIPTIONS	PAT. DAYS	463,927	14	27		30,221	2	7
8	21	OFFICE EXPENSES	PAT. DAYS	463,927	14	6,517		30,221	425	8
9	24	SEMINAR & LODGING EXPEN	PAT. DAYS	463,927	14	2,370		30,221	154	9
10	25	AUTO EXPENSE	PAT. DAYS	463,927	14	42,910		30,221	2,795	10
11	27	ADMINISTRATIVE & OFFICE	PAT. DAYS	463,927	14	51,458		30,221	3,352	11
12	35	AUTO LEASE	PAT. DAYS	463,927	14	133		30,221	9	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		\$ 78,546	25

Facility Name & ID Number Rosewood Care Center Of Galesburg# 0049791

Report Period Beginning:

07/01/15Ending: 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 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	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	17	CONSULTING FEES	PATIENT DAYS	463,927	14	\$ 100,000	\$ 30,221	\$ 6,514	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	463,927	14	266,160	30,221	17,338	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	463,927	14	3,410	30,221	222	3
4	21	OFFICE EXPENSE	PATIENT DAYS	463,927	14	4,609	30,221	300	4
5	24	SEMINAR EXPENSE	PATIENT DAYS	463,927	14	4,112	30,221	268	5
6	25	AUTO & TRAVEL EXPENSE	PATIENT DAYS	463,927	14	20,788	30,221	1,354	6
7	32	INTEREST	PATIENT DAYS	463,927	14	(17,495)	30,221	(1,140)	7
8	35	AUTO RENTAL	PATIENT DAYS	463,927	14	85	30,221	6	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	\$	\$ 24,863	25

Facility Name & ID Number Rosewood Care Center Of Galesburg# 0049791

Report Period Beginning:

07/01/15Ending: 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 SENIOR LIVING SERVICES, INC.
 Street Address 11701 BORMAN DRIVE, SUITE 315
 City / State / Zip Code ST. LOUIS, MO 63146
 Phone Number (314) 994-9070
 Fax Number (314) 994-9912

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	ACTUAL FEES	14	\$ 3,017	\$	61,480	\$ 200	1
2	6	MAINTENANCE SALARY	ACTUAL FEES	14	435,123	435,123	61,480	28,774	2
3	6	MAINTENANCE EXPENSE	ACTUAL FEES	14	44,153		61,480	2,920	3
4	7	MAINTENANCE BENEFITS	ACTUAL FEES	14	61,694		61,480	4,080	4
5	19	PROFESSIONAL FEES	ACTUAL FEES	14	1,467		61,480	97	5
6	20	LICENSES	ACTUAL FEES	14	1,402		61,480	93	6
7	21	OFFICE EXPENSE	ACTUAL FEES	14	5,306		61,480	351	7
8	25	AUTO / TRAVEL EXPENSE	ACTUAL FEES	14	36,073		61,480	2,385	8
9	26	INSURANCE	ACTUAL FEES	14	12,121		61,480	801	9
10	30	DEPRECIATION	ACTUAL FEES	14	13,517		61,480	894	10
11	35	AUTO LEASE	ACTUAL FEES	14	135		61,480	9	11
12	6	MAINTENANCE SUPPLIES	DIRECT ALLOCATION	13	6,541			17	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		\$ 40,621	25

Facility Name & ID Number Rosewood Care Center Of Galesburg# 0049791

Report Period Beginning:

07/01/15Ending: 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 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 Galesburg # 0049791 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

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 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

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

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	MidCap		X	Mortgage	250000 + Int		\$ 12,000,000	\$ 7,500,000			\$ 1,279,786	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	MidCap		X	Line of Credit				5,404,175			308,700	6	
7	MidCap (Bldg. Co)		X	Note Payable				7,491,463			370,724	7	
8	See Supplemental Schedule										16,553	8	
9	TOTAL Facility Related						\$ 12,000,000	\$ 20,395,638			\$ 1,975,762	9	
	B. Non-Facility Related*												
10	Less: Interest Income Offset											10	
11	Allocated from Bravo Holding Company										(1,140)	11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (1,140)	14	
15	TOTALS (line 9+line14)						\$ 12,000,000	\$ 20,395,638			\$ 1,974,622	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 - 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	Allocated from Midwest Admin Services, Inc						\$				\$ 16,553	8	
9												9	
10												10	
11												11	
12												12	
13												13	
14	TOTAL Working Capital										16,553	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.)

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

SEE ACCOUNTANTS' COMPILATION REPORT

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.		\$	149,234	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.)				\$	150,291	2
3. Under or (over) accrual (line 2 minus line 1).				\$	1,057	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	150,210	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.				\$	151,267	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2011	139,343	8	FOR BHF USE ONLY	
		2012	139,437	9		
		2013	145,055	10		
		2014	148,301	11		
		2015	152,281	12		
Accrual based on prior year tax bill.				13	FROM R. E. TAX STATEMENT FOR 2015	13
Amount on line 2 includes 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.

FACILITY NAME	<u>Rosewood Care Center Of Galesburg</u>	COUNTY	<u>Knox</u>
FACILITY IDPH LICENSE NUMBER	<u>0049791</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>Steve Lavenda</u>		
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.

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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Rosewood Care Center Of Galesburg</u>	COUNTY	<u>Knox</u>
---------------	--	--------	-------------

FACILITY IDPH LICENSE NUMBER 0049791

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.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?

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.

A. Square Feet: 38,331

B. General Construction Type: Exterior BrickFrame WoodNumber 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).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	5 Acres	1987	\$ 182,779	1
2					2
3	TOTALS			\$ 182,779	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		1987	1987	\$ 2,297,757	\$ 157,715	25-40	\$ 68,790	\$ (88,925)	\$ 1,888,447	4
5	60		1998	1998	2,243,326		25-40	72,617	72,617	1,364,421	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)	452,409			12,415	12,415	269,905	67
68	Related Party Allocations (Pages 12H & 12I)							68
69	Financial Statement Depreciation		17,020			(17,020)		69
70	TOTAL (lines 4 thru 69)	\$ 4,993,492	\$ 174,735		\$ 153,822	\$ (20,913)	\$ 3,522,773	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	\$ 4,993,492	\$ 174,735		\$ 153,822	\$ (20,913)	\$ 3,522,773	1
2	Install Check Valves/Return Line/Holbi Valve/ And Heater Piping	2015	3,981		20	199	199	2
3	Electrical; Fire System Tripped	2016	3,884		20	194	194	3
4	Ground Fault Isolation/Replacement In Lobby/Nurses Station/600	2016	2,810		20	141	141	4
5	Replacement Fire Alarm Control Panel & Annunciators	2016	2,978		20	149	149	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
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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)	\$ 5,007,145	\$ 174,735		\$ 154,505	\$ (20,230)	\$ 3,523,456	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		\$ 5,007,145	\$ 174,735		\$ 154,505	\$ (20,230)	\$ 3,523,456	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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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)		\$ 5,007,145	\$ 174,735		\$ 154,505	\$ (20,230)	\$ 3,523,456	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		\$ 5,007,145	\$ 174,735		\$ 154,505	\$ (20,230)	\$ 3,523,456	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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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)		\$ 5,007,145	\$ 174,735		\$ 154,505	\$ (20,230)	\$ 3,523,456	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		\$ 5,007,145	\$ 174,735		\$ 154,505	\$ (20,230)	\$ 3,523,456	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)		\$ 5,007,145	\$ 174,735		\$ 154,505	\$ (20,230)	\$ 3,523,456	34

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

Facility Name & ID Number Rosewood Care Center Of Galesburg

0049791

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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Building Company		\$	\$		\$	\$	\$	1
2								2
3								3
4								4
5								5
6								6
7								7
8 Leasehold Improvements:								8
9 Facility Signage	1887	3,423		10			3,423	9
10 Exhaust Hood & Fire Suppression System	1987	9,019		10			9,019	10
11 Nurse Call System & Paging System	1987	45,340		10			45,340	11
12 Seeding / Landscaping / Berm	1988	31,414		25			31,414	12
13 18 Bed Addition	1989	49,460		40	1,237	1,237	33,190	13
14 Painting	1991	1,360		10			1,360	14
15 Facility Signage	1991	3,733		10			3,733	15
16 Painting	1992	1,520		10			1,520	16
17 Roof Vents	1992	6,896		40	172	172	4,180	17
18 Parking Lot Improvements	1992	5,673		25	227	227	5,427	18
19 Water Heaters	1992	3,123		10			3,123	19
20 Irrigation System	1994	7,253		25	290	290	6,673	20
21 Landscaping	1998	3,183		25	127	127	2,291	21
22 Shingle Roof Replacement	2002	102,091		40	2,552	2,552	37,220	22
23 Seal & Restripe Parking Lot	2003	14,545		25	582	582	7,515	23
24 Repair Soffit & Facia on Gables	2003	5,394		40	135	135	1,709	24
25 Air Conditioning Unit & Heat Pumps	2003	9,817		10			9,817	25
26 Boiler	2003	20,269		10			20,269	26
27 Heat Pumps	2004	2,875		10			2,875	27
28 Paint Exterior of Building	2005	2,875		40	72	72	821	28
29 Fire Alarm Panel	2005	2,647		10	44	44	2,647	29
30 Console Heat Pumps	2006	6,337		10	422	422	6,337	30
31 Seal & Stripe Parking Lot	2006	5,195		25	208	208	1,992	31
32 Replace Sidewalk	2007	5,778		40	144	144	1,251	32
33 Seal & Stripe Parking Lot	2008	6,245		25	250	250	1,999	33
34 TOTAL (lines 1 thru 33)		\$ 355,465	\$		\$ 6,462	\$ 6,462	\$ 245,145	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12F, Carried Forward		\$ 355,465	\$		\$ 6,462	\$ 6,462	\$ 245,145	1
2 Shower Improvements	2008	10,336		40	258	258	2,045	2
3 Heat Pumps	2009	4,218		10	422	422	2,812	3
4 Seal & Stripe Parking Lot	2010	6,975		25	279	279	1,674	4
5 Generator	2010	4,888		10	489	489	2,729	5
6 Doors	2011	14,790		10	1,479	1,479	7,025	6
7 Sprinkler	2012	6,753		10	675	675	2,982	7
8 Sprinkler	2012	3,704		40	93	93	363	8
9 Boiler / Burner / Pump	2013	8,358		40	209	209	627	9
10 New Window Sills & Counters	2013	3,710		40	93	93	279	10
11 Firestopping Corridor Controls	2013	5,012		40	125	125	354	11
12 HVAC Improvements	2014	8,156		10	816	816	2,040	12
13 Seal Coating & Asphalt Repair - Front & Back Lot & Drive	2014	12,885		25	515	515	902	13
14 Replace Hot Water Heater in Laundry	2014	4,279		10	428	428	856	14
15 Fire Alarm Control Panel	2016	2,880		10	72	72	72	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)		\$ 452,409	\$		\$ 12,415	\$ 12,415	\$ 269,905	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
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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)

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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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	\$950,007	\$2,629	\$23,542	\$20,913	10	\$889,963	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	15,147	112	112		10	15,147	73
74								74
75	TOTALS	\$965,154	\$2,741	\$23,654	\$20,913		\$905,110	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 Midwest Adminis	Various	\$45,984	\$11,724	\$11,724		5	\$29,887	76
77		Allocated from Senior Living Ser	Various	9,898	894	894		5	9,262	77
78										78
79										79
80	TOTALS			\$55,882	\$12,618	\$12,618			\$39,149	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$6,210,960	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$190,094	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$190,777	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$683	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$4,467,715	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				3,864			5
6	Allocated from Midwest Admin Services				13,452			6
7	TOTAL				\$ 17,316			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 Services, Inc		\$	\$ 9	17
18	Allocated from Senior Living Services, Inc			9	18
19	Allocated from Bravo Holding Company			6	19
20					20
21	TOTAL		\$	\$ 24	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	\$		\$ 183,975	\$		\$ 183,975	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			17,186			17,186	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			212,848			212,848	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				96,802		96,802	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)									
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					4,167	11,789		15,956	13
14	TOTAL			\$		\$ 418,176	\$ 108,591		\$ 526,767	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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 22,998	\$ 74,794	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,629,916	1,629,916	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	65,593	69,872	6
7	Other Prepaid Expenses	1,524	1,524	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	2,000	2,000	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,722,031	\$ 1,778,106	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		4,806,863	14
15	Leasehold Improvements, at Historical Cost		695,461	15
16	Equipment, at Historical Cost	85,099	1,092,101	16
17	Accumulated Depreciation (book methods)	(57,456)	(4,406,520)	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)	\$ 27,643	\$ 2,370,684	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,749,674	\$ 4,148,790	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,496,615	\$ 1,518,515	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	5,404,175	5,404,175	29
30	Accrued Salaries Payable	136,211	136,211	30
31	Accrued Taxes Payable (excluding real estate taxes)	129,911	129,911	31
32	Accrued Real Estate Taxes(Sch.IX-B)		150,210	32
33	Accrued Interest Payable		589,118	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	14,235	35,105	35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	2,006,297	577,868	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 9,187,444	\$ 8,541,113	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		14,991,463	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)	\$	\$ 14,991,463	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 9,187,444	\$ 23,532,576	46
47	TOTAL EQUITY(page 18, line 24)	\$ (7,437,770)	\$ (19,383,786)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,749,674	\$ 4,148,790	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (5,838,672)	1
2	Restatements (describe):		2
3	Late Entries	(11,215)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (5,849,887)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,587,883)	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)	\$ (1,587,883)	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)	\$ (7,437,770)	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	\$ 5,373,949	1
2	Discounts and Allowances for all Levels	(1,019,868)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,354,081	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,059,407	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,059,407	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	2,475	13
14	Non-Patient Meals	3,793	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	105,727	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,180	19
20	Radiology and X-Ray	2,612	20
21	Other Medical Services	40,580	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 164,367	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	12,594	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 12,594	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,590,449	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,519,890	31
32	Health Care	2,164,597	32
33	General Administration	1,347,611	33
	B. Capital Expense		
34	Ownership	1,296,439	34
	C. Ancillary Expense		
35	Special Cost Centers	590,038	35
36	Provider Participation Fee	259,757	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,178,332	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,587,883)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,587,883)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,324,989	44
45	Private Pay - Net Inpatient Revenue	1,474,076	45
46	Medicare - Net Inpatient Revenue	485,335	46
47	Other-(specify) Insurance/ Managed Care Allowances	69,681	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,354,081	49

* This must agree with page 4, line 45, column 4.
** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.
*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.
****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Rosewood Care Center Of Galesburg

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	2,225	2,570	\$ 65,154	\$ 25.35	1
2	Assistant Director of Nursing	1,537	1,649	37,862	22.96	2
3	Registered Nurses	15,764	17,240	388,388	22.53	3
4	Licensed Practical Nurses	23,639	25,804	480,290	18.61	4
5	CNAs & Orderlies	66,898	72,345	741,779	10.25	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,667	4,103	57,441	14.00	8
9	Activity Director	2,080	2,320	24,143	10.41	9
10	Activity Assistants	2,848	3,021	26,672	8.83	10
11	Social Service Workers	4,323	4,633	59,189	12.78	11
12	Dietician					12
13	Food Service Supervisor	135	191	3,907	20.46	13
14	Head Cook					14
15	Cook Helpers/Assistants	2,561	3,454	29,335	8.49	15
16	Dishwashers					16
17	Maintenance Workers	2,134	2,278	31,605	13.87	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,113	2,466	87,242	35.38	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,702	9,390	100,201	10.67	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	2,633	2,872	31,801	11.07	31
32	Other Health Care(specify)					32
33	Other(specify)	3,082	3,506	58,345	16.64	33
34	TOTAL (lines 1 - 33)	143,341	157,842	\$ 2,223,354 *	\$ 14.09	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	\$ 785	01-03	35
36	Medical Director	Monthly	13,863	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,235	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	3,000	11-03	44
45	Social Service Consultant	Monthly	3,000	12-03	45
46	Other(specify) Outsourced Dietary	Monthly	348,157	01-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 377,040		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	40	\$ 1,644	10-03	50
51	Licensed Practical Nurses	684	27,293	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	725	\$ 28,937		53

line 20, col. 8)	
G. Schedule of Travel and Seminar**	
Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	640
Allocated from Midwest Admin Services	437
Allocated from Bravo Nursing Home Services	154
See Supplemental Schedule	268
Entertainment Expense	(
(agree to Sch. V, line 24, col. 8)	)
TOTAL	\$ 1,499

****See instructions.**

Facility Name & ID Number		Rosewood Care Center Of Galesburg		STATE OF ILLINOIS	#	0049791	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?			<u>No</u>							
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount.			<u>Yes</u> <u>IHCA: \$10,303.20</u>							
(3)	Did the nursing home make political contributions or payments to a political action organization? If YES, have these costs been properly adjusted out of the cost report?			<u>Yes</u> <u>Yes</u>							
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? If YES, what is the capacity?			<u>No</u>							
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period?			<u>Yes</u> <u>10 Years</u>							
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.			\$ <u>44,399</u> Line <u>10</u>							
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? If NO, attach a complete explanation.			<u>Yes</u>							
(8)	Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease.			<u>No</u> <u>N/A</u>							
(9)	Are you presently operating under a sublease agreement?			YES <u>X</u> NO							
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES <u>NO</u> <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.			<u>N/A</u>							
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. This amount is to be recorded on line 42 of Schedule V.			\$ <u>259,757</u>							
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? If YES, attach an explanation of the allocation.			<u>No</u>							
(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?			<u>Yes</u>							
(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? 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.			<u>No</u>							
(15)	Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. Has any meal income been offset against related costs?			\$ <u>Yes</u> Indicate the amount. \$ <u>3,793</u>							
(16)	Travel and Transportation										
	a. Are there costs included for out-of-state travel? If YES, attach a complete explanation.			<u>No</u>							
	b. Do you have a separate contract with the Department to provide medical transportation for residents? If YES, please indicate the amount of income earned from such a program during this reporting period.			<u>No</u> \$ <u>N/A</u>							
	c. What percent of all travel expense relates to transportation of nurses and patients?			<u>N/A</u>							
	d. Have vehicle usage logs been maintained?			<u>N/A</u>							
	e. Are all vehicles stored at the nursing home during the night and all other times when not in use?			<u>N/A</u>							
	f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?			<u>N/A</u>							
	g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period.			<u>No</u> \$ <u>N/A</u>							
(17)	Has an audit been performed by an independent certified public accounting firm? Firm Name:			<u>N/A</u>							
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?			<u>Yes</u>							
(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. Attach invoices and a summary of services for all architect and appraisal fees			<u>Yes</u>							