

		FOR BHF USE				

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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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

<p>I. IDPH License ID Number: <u>0049346</u></p> <p>Facility Name: <u>Rosewood Care Ctr of Elgin</u></p> <p>Address: <u>2355 Royal Boulevard</u> <u>Elgin</u> <u>60123</u> <small>Number City Zip Code</small></p> <p>County: <u>Kane</u></p> <p>Telephone Number: <u>(847)888-9585</u> Fax # <u>(847)888-4173</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>12/1/2007</u></p> <p>Type of Ownership:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width: 33%; vertical-align: top;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Larry Templin</u> Telephone Number: <u>(630) 361-2868</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/2013</u> to <u>06/30/2014</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%; padding: 5px; vertical-align: top;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td style="padding: 5px; vertical-align: top;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____ (Print Name and Title) <u>Larry Templin Partner</u> (Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525</u> (Telephone) <u>(630) 361-2868</u> Fax # () _____</td> </tr> </table> <p style="text-align: right; margin-top: 10px;">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</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) <u>Larry Templin Partner</u> (Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525</u> (Telephone) <u>(630) 361-2868</u> Fax # () _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____							
Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) <u>Larry Templin Partner</u> (Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525</u> (Telephone) <u>(630) 361-2868</u> Fax # () _____							

Facility Name & ID Number Rosewood Care Ctr of Elgin

0049346 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	139	Skilled (SNF)	139	50,735	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	139	TOTALS	139	50,735	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	113	8,099	10,346	18,558	8
9	SNF/PED					9
10	ICF	15,912	7,673		23,585	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,025	15,772	10,346	42,143	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.06%

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

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES NO Non-allowable costs have been eliminated in Schedule V, Column 7

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

YES NO

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

Date started 12/01/2007

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

YES Date 12/01/2007 NO

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

YES NO If YES, enter number of beds certified 67 and days of care provided 9,443

Medicare Intermediary Novitas Solutions, Inc.

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number

Rosewood Care Ctr of Elgin

0049346

Report Period Beginning:

07/01/2013

Ending:

06/30/2014

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	250,678	33,186	18,437	302,301		302,301	2,062	304,363		1
2	Food Purchase		263,106		263,106		263,106	(6,574)	256,532		2
3	Housekeeping	172,159	47,436		219,595		219,595		219,595		3
4	Laundry	37,918	16,162		54,080		54,080		54,080		4
5	Heat and Other Utilities			185,097	185,097		185,097	269	185,366		5
6	Maintenance	34,051	8,040	250,922	293,013		293,013	(39,398)	253,615		6
7	Other (specify):* <i>Allocated HO Benefits</i>							5,512	5,512		7
8	TOTAL General Services	494,806	367,930	454,456	1,317,192		1,317,192	(38,129)	1,279,063		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	3,319,922	240,144	12,933	3,572,999		3,572,999	57,051	3,630,050		10
10a	Therapy		4,062	975,484	979,546		979,546		979,546		10a
11	Activities	60,136	4,109	2,600	66,845		66,845		66,845		11
12	Social Services	87,714		2,600	90,314		90,314		90,314		12
13	CNA Training										13
14	Program Transportation			737	737		737		737		14
15	Other (specify):* <i>Allocated HO Benefits</i>							4,810	4,810		15
16	TOTAL Health Care and Programs	3,467,772	248,315	1,006,354	4,722,441		4,722,441	61,861	4,784,302		16
	C. General Administration										
17	Administrative	91,967		308,024	399,991		399,991	(287,951)	112,040		17
18	Directors Fees										18
19	Professional Services			221,113	221,113		221,113	112,846	333,959		19
20	Dues, Fees, Subscriptions & Promotions			16,155	16,155		16,155	(933)	15,222		20
21	Clerical & General Office Expenses	130,054	17,499	43,448	191,001		191,001	190,061	381,062		21
22	Employee Benefits & Payroll Taxes			536,165	536,165		536,165		536,165		22
23	Inservice Training & Education			360	360		360		360		23
24	Travel and Seminar			403	403		403	7,741	8,144		24
25	Other Admin. Staff Transportation			2,638	2,638		2,638	8,431	11,069		25
26	Insurance-Prop.Liab.Malpractice			53,817	53,817		53,817	44,299	98,116		26
27	Other (specify):* <i>Allocated HO Benefits</i>							17,925	17,925		27
28	TOTAL General Administration	222,021	17,499	1,182,123	1,421,643		1,421,643	92,419	1,514,062		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,184,599	633,744	2,642,933	7,461,276		7,461,276	116,151	7,577,427		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Rosewood Care Ctr of Elgin

#0049346

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			13,290	13,290	13,290	56,240	69,530				30
31	Amortization of Pre-Op. & Org.											31
32	Interest						164,272	164,272				32
33	Real Estate Taxes						41,860	41,860				33
34	Rent-Facility & Grounds			1,427,530	1,427,530	1,427,530	(593,466)	834,064				34
35	Rent-Equipment & Vehicles			18,193	18,193	18,193	12,300	30,493				35
36	Other (specify):*											36
37	TOTAL Ownership			1,459,013	1,459,013	1,459,013	(318,794)	1,140,219				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		409,133		409,133	409,133		409,133				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			272,959	272,959	272,959		272,959				42
43	Other (specify):* See Att Sch 4A	96,742		297,991	394,733	394,733	(347,250)	47,483				43
44	TOTAL Special Cost Centers	96,742	409,133	570,950	1,076,825	1,076,825	(347,250)	729,575				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,281,341	1,042,877	4,672,896	9,997,114	9,997,114	(549,893)	9,447,221				45

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

Rosewood Care Ctr of Elgin

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

Schedule 4A

V. Cost Center Expenses

		Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					5	6
		1	2	3	4	5	6	7	8	9	10
	Ancillary Expense										
	E. Special Cost Centers										
43	Other (specify):*				0		0		0		
	Laboratory Expense			12,376	12,376		12,376		12,376		
	Radiology Expenses			35,107	35,107		35,107		35,107		
	Non-Allowable Expenses	96,742		250,508	347,250		347,250	(347,250)	0		
					0		0		0		
					0		0		0		
	TOTAL Other Special Cost Centers	96,742	0	297,991	394,733	0	394,733	(347,250)	47,483		

Facility Name & ID Number Rosewood Care Ctr of Elgin

0049346

Report Period Beginning: 07/01/2013

Ending: 06/30/2014

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,042)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,280)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(55,938)	30		9
10	Interest and Other Investment Income	(27,248)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,567)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(3,054)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,308)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(238,722)	43		24
25	Fund Raising, Advertising and Promotional	(2,913)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(593)	43		28
29	Other-Attach Schedule See Page 5A	(98,759)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (447,424)		\$	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
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(102,469)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (102,469)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (549,893)		37

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

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

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

Rosewood Care Ctr of Elgin

ID# 0049346

Report Period Beginning: 07/01/2013

Ending: 06/30/2014

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Eliminate Marketing Salary	\$ (96,742)	43	1
2	Miscellaneous Income Offset	(1,128)	21	2
3	Disallow Marketing Mileage Reimbursement	(889)	25	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(98,759)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Ctr of Elgin# 0049346

Report Period Beginning:

07/01/2013

Ending:

06/30/2014

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	2,062	0	0	0	0	0	0	0	0	2,062	1
2	Food Purchase	(6,609)	0	35	0	0	0	0	0	0	0	0	(6,574)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	242	0	27	0	0	0	0	0	0	269	5
6	Maintenance	0	0	180	0	(39,578)	0	0	0	0	0	0	(39,398)	6
7	Other (specify):*	0	0	233	0	5,279	0	0	0	0	0	0	5,512	7
8	TOTAL General Services	(6,609)	0	2,752	0	(34,272)	0	0	0	0	0	0	(38,129)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	51,801	5,250	0	0	0	0	0	0	0	0	57,051	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	4,217	593	0	0	0	0	0	0	0	0	4,810	15
16	TOTAL Health Care and Programs	0	56,018	5,843	0	0	0	0	0	0	0	0	61,861	16
	C. General Administration													
17	Administrative	0	(120,469)	(171,082)	0	0	3,600	0	0	0	0	0	(287,951)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,308)	132	10,062	(12,985)	0	118,697	2,248	0	0	0	0	112,846	19
20	Fees, Subscriptions & Promotions	(3,054)	13	1,777	321	10	0	0	0	0	0	0	(933)	20
21	Clerical & General Office Expenses	(1,128)	59,162	113,943	15,585	811	537	1,151	0	0	0	0	190,061	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	2,093	3,438	128	2,004	78	0	0	0	0	0	7,741	24
25	Other Admin. Staff Transportation	(889)	3,163	1,484	312	4,361	0	0	0	0	0	0	8,431	25
26	Insurance-Prop.Liab.Malpractice	0	360	2,359	164	1,256	579	39,581	0	0	0	0	44,299	26
27	Other (specify):*	0	6,144	10,294	1,487	0	0	0	0	0	0	0	17,925	27
28	TOTAL General Administration	(10,379)	(49,402)	(27,725)	5,012	8,442	119,891	46,580	0	0	0	0	92,419	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(16,988)	6,616	(19,130)	5,012	(25,830)	119,891	46,580	0	0	0	0	116,151	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Ctr of Elgin# 0049346

Report Period Beginning:

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

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(55,938)	0	7,894	0	1,354	0	102,930	0	0	0	0	56,240	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(27,248)	0	568	81	0	19,937	170,934	0	0	0	0	164,272	32
33	Real Estate Taxes	0	0	0	0	0	0	41,860	0	0	0	0	41,860	33
34	Rent-Facility & Grounds	0	0	7,099	0	0	0	(600,565)	0	0	0	0	(593,466)	34
35	Rent-Equipment & Vehicles	0	10,841	1,459	0	0	0	0	0	0	0	0	12,300	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(83,186)	10,841	17,020	81	1,354	19,937	(284,841)	0	0	0	0	(318,794)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(347,250)	0	0	0	0	0	0	0	0	0	0	(347,250)	43
44	TOTAL Special Cost Centers	(347,250)	0	0	0	0	0	0	0	0	0	0	(347,250)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(447,424)	17,457	(2,110)	5,093	(24,476)	139,828	(238,261)	0	0	0	0	(549,893)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>Bravo Services, L.L.C.</u>	<u>100</u>	<u>See Page 6 - Supplemental</u>		<u>See Page 6 - Supplemental</u>		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	<u>10 Nursing & Medical Records</u>	\$	<u>Bravo Nursing Home Services, Inc.</u>	<u>0.00%</u>	\$ <u>51,801</u>	\$ <u>51,801</u>	1
2	V	<u>15 Mgmt. Allocation of Benefits</u>		<u>Bravo Nursing Home Services, Inc.</u>	<u>0.00%</u>	<u>4,217</u>	<u>4,217</u>	2
3	V	<u>17 Mgmt Fee/Administrative</u>	<u>138,000</u>	<u>Bravo Nursing Home Services, Inc.</u>	<u>0.00%</u>	<u>17,531</u>	<u>(120,469)</u>	3
4	V	<u>19 Professional Services</u>		<u>Bravo Nursing Home Services, Inc.</u>	<u>0.00%</u>	<u>132</u>	<u>132</u>	4
5	V	<u>20 Dues, Fees, Subs & Promotions</u>		<u>Bravo Nursing Home Services, Inc.</u>	<u>0.00%</u>	<u>13</u>	<u>13</u>	5
6	V	<u>21 Clerical and General Office</u>		<u>Bravo Nursing Home Services, Inc.</u>	<u>0.00%</u>	<u>59,162</u>	<u>59,162</u>	6
7	V	<u>24 Travel and Seminar</u>		<u>Bravo Nursing Home Services, Inc.</u>	<u>0.00%</u>	<u>2,093</u>	<u>2,093</u>	7
8	V	<u>25 Other Admin. Staff Transport.</u>		<u>Bravo Nursing Home Services, Inc.</u>	<u>0.00%</u>	<u>3,163</u>	<u>3,163</u>	8
9	V	<u>26 Insurance-Prop./Liab./Malprac.</u>		<u>Bravo Nursing Home Services, Inc.</u>	<u>0.00%</u>	<u>360</u>	<u>360</u>	9
10	V	<u>27 Mgmt. Allocation of Benefits</u>		<u>Bravo Nursing Home Services, Inc.</u>	<u>0.00%</u>	<u>6,144</u>	<u>6,144</u>	10
11	V	<u>35 Rent-Equipment & Vehicles</u>		<u>Bravo Nursing Home Services, Inc.</u>	<u>0.00%</u>	<u>10,841</u>	<u>10,841</u>	11
12	V							12
13	V							13
14	Total		\$ 138,000			\$ 155,457	\$ * 17,457	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	<u>1</u> Dietary	\$	Midwest Administrative Services, Inc.	0.00%	\$ 2,062	\$	2,062	15
16	V	<u>2</u> Food		Midwest Administrative Services, Inc.	0.00%	35		35	16
17	V	<u>5</u> Utilities		Midwest Administrative Services, Inc.	0.00%	242		242	17
18	V	<u>6</u> Maintenance		Midwest Administrative Services, Inc.	0.00%	180		180	18
19	V	<u>7</u> Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	233		233	19
20	V	<u>10</u> Nursing and Medical Records		Midwest Administrative Services, Inc.	0.00%	5,250		5,250	20
21	V	<u>15</u> Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	593		593	21
22	V	<u>17</u> Mgmt Fee/Administrative	173,624	Midwest Administrative Services, Inc.	0.00%	2,542		(171,082)	22
23	V	<u>19</u> Professional Services		Midwest Administrative Services, Inc.	0.00%	10,062		10,062	23
24	V	<u>20</u> Dues, Fees, Subs & Promotions		Midwest Administrative Services, Inc.	0.00%	1,777		1,777	24
25	V	<u>21</u> Clerical and General Office		Midwest Administrative Services, Inc.	0.00%	113,943		113,943	25
26	V	<u>24</u> Travel and Seminar		Midwest Administrative Services, Inc.	0.00%	3,438		3,438	26
27	V	<u>25</u> Other Admin. Staff Transport.		Midwest Administrative Services, Inc.	0.00%	1,484		1,484	27
28	V	<u>26</u> Insurance-Prop./Liab./Malprac.		Midwest Administrative Services, Inc.	0.00%	2,359		2,359	28
29	V	<u>27</u> Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	10,294		10,294	29
30	V	<u>30</u> Depreciation		Midwest Administrative Services, Inc.	0.00%	7,894		7,894	30
31	V	<u>32</u> Interest		Midwest Administrative Services, Inc.	0.00%	568		568	31
32	V	<u>34</u> Rent-Facility and Grounds		Midwest Administrative Services, Inc.	0.00%	7,099		7,099	32
33	V	<u>35</u> Rent-Equipment & Vehicles		Midwest Administrative Services, Inc.	0.00%	1,459		1,459	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 173,624			\$ 171,514	\$ *	(2,110)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 Professional Services	\$ 13,743	Claims Administration Services, LLC		\$ 758	\$ (12,985)
16	V	20 Dues, Fees, Subs & Promotions		Claims Administration Services, LLC		321	321
17	V	21 Clerical and General Office		Claims Administration Services, LLC		15,585	15,585
18	V	24 Travel and Seminar		Claims Administration Services, LLC		128	128
19	V	25 Other Admin. Staff Transport.		Claims Administration Services, LLC		312	312
20	V	26 Insurance-Prop./Liab./Malprac.		Claims Administration Services, LLC		164	164
21	V	27 Mgmt. Allocation of Benefits		Claims Administration Services, LLC		1,487	1,487
22	V	32 Interest		Claims Administration Services, LLC		81	81
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 13,743			\$ 18,836	\$ * 5,093

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 Utilities	\$	Senior Living Services, Inc.	0.00%	\$ 27	\$	27	15
16	V	6 Maintenance	125,313	Senior Living Services, Inc.	0.00%	85,735		(39,578)	16
17	V	7 Mgmt. Allocation of Benefits		Senior Living Services, Inc.	0.00%	5,279		5,279	17
18	V	20 Dues, Fees, Subs & Promotions		Senior Living Services, Inc.	0.00%	10		10	18
19	V	21 Clerical and General Office		Senior Living Services, Inc.	0.00%	811		811	19
20	V	24 Travel and Seminar		Senior Living Services, Inc.	0.00%	2,004		2,004	20
21	V	25 Other Admin. Staff Transport.		Senior Living Services, Inc.	0.00%	4,361		4,361	21
22	V	26 Insurance-Prop./Liab./Malprac.		Senior Living Services, Inc.	0.00%	1,256		1,256	22
23	V	30 Depreciation		Senior Living Services, Inc.	0.00%	1,354		1,354	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 125,313			\$ 100,837	\$ *	(24,476)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	19 Professional Services	\$	Bravo Holding Company	0.00%	\$ 118,697	\$	118,697	15
16	V	21 Clerical and General Office		Bravo Holding Company	0.00%	537		537	16
17	V	24 Travel and Seminar		Bravo Holding Company	0.00%	78		78	17
18	V	26 Insurance-Prop./Liab./Malprac.		Bravo Holding Company	0.00%	579		579	18
19	V	32 Interest		Bravo Holding Company	0.00%	19,937		19,937	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		\$			\$ 139,828	\$ *	139,828	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 Administrative	\$	Elgin Real Estate, LLC	0.00%	\$ 3,600	\$ 3,600
16	V	19 Professional Services		Elgin Real Estate, LLC	0.00%	2,248	2,248
17	V	21 Clerical and General Office		Elgin Real Estate, LLC	0.00%	1,151	1,151
18	V	26 Insurance-Prop./Liab./Malprac.		Elgin Real Estate, LLC	0.00%	39,581	39,581
19	V	30 Depreciation		Elgin Real Estate, LLC	0.00%	102,930	102,930
20	V	32 Interest		Elgin Real Estate, LLC	0.00%	170,934	170,934
21	V	33 Real Estate Taxes		Elgin Real Estate, LLC	0.00%	41,860	41,860
22	V	34 Rent-Facility and Grounds	600,565	Elgin Real Estate, LLC	0.00%		(600,565)
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 600,565			\$ 362,304	\$ * (238,261)

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

Facility Name & ID Number

Rosewood Care Ctr of Elgin

0049346

Report Period Beginning:

07/01/2013

Ending:

06/30/2014

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2			Bravo Care of East Alton, Inc.	Alton, IL	Bravo Care of Wood		Supportive Living	2
3			Bravo Care of East Peoria, Inc.	East Peoria, IL	River, Inc.	Wood River, IL	Facility	3
4			Bravo Care of Edwardsville, Inc.	Edwardsville, IL	Bravo Nursing Home			4
5			Bravo Care of Galeburg, Inc.	Galesburg, IL	Services, Inc.	St. Louis, MO	Management Co.	5
6			Bravo Care of Inverness, Inc.	Inverness, IL	Bravo Holding			6
7			Bravo Care of Joliet, Inc.	Joliet, IL	Company, Inc.	St. Louis, MO	Holding Co.	7
8			Bravo Care of Moline, Inc.	Moline, IL	Senior Living		Building Services	8
9			Bravo Care of Northbrook, Inc.	Northbrook, IL	Services, Inc.	St. Louis, MO	Company	9
10			Bravo Care of Peoria, Inc.	Peoria, IL	Bravo Team		Human Resources	10
11			Bravo Care of Rockford, Inc.	Rockford, IL	Health, Inc.	St. Louis, MO	Company	11
12			Bravo Care of St. Charles, Inc.	St. Charles, IL	Claims Administration		Legal Services	12
13			Bravo Care of St. Louis, Inc.	St. Louis, MO	Services, LLC	St. Louis, MO		13
14					Elgin Real Estate, LLC	Elgin, IL	Lessor	14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Rosewood Care Ctr of Elgin # 0049346 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Michael Brady	President (Note 1)	Administrative	0.00	94,677	4.24	8.48	Salary	\$ 8,766	L17, C7	1
2	Mark Yampol	CEO (Note 2)	Administrative	0.00	27,460	4.24	8.48	Salary	2,542	L17, C7	2
3											3
4											4
5											5
6											6
7											7
8											8
9	Note 1: Michael Brady was the President of Bravo Nursing Home Services, Inc. from 7/1/13 to 12/30/13. When the stock of the companies were sold, Mr. Brady became										9
10	Director of Administrative Services and was no longer President. The wages above reflect only the period of time from when he was President.										10
11	Note 2: Mark Yampol is the CEO of Midwest Administrative Services, Inc. beginning 12/31/13, when the stock of the companies were purchased.										11
12	The wages above reflect only the period of time from 12/31/13 thru 6/30/14.										12
13								TOTAL	\$ 11,308		13

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

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

Facility Name & ID Number Rosewood Care Ctr of Elgin

0049346 Report Period Beginning: 07/01/2013

Ending: 6/30/2014

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5** Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
1	10	Nursing & Medical Records	WeightedCensus	497,328	15	611,304	611,304	42,143	\$ 51,801	1
2	15	Mgmt. Allocation of Benefits	WeightedCensus	497,328	15	49,766	42,143	42,143	4,217	2
3	17	Administrative	WeightedCensus	497,328	15	206,886	206,886	42,143	17,531	3
4	19	Professional Services	WeightedCensus	497,328	15	1,560	42,143	42,143	132	4
5	20	Dues, Fees, Subs & Promotions	WeightedCensus	497,328	15	155	42,143	42,143	13	5
6	21	Clerical and General Office	WeightedCensus	497,328	15	698,165	683,784	42,143	59,162	6
7	24	Travel and Seminar	WeightedCensus	497,328	15	24,702	42,143	42,143	2,093	7
8	25	Other Admin. Staff Transport.	WeightedCensus	497,328	15	37,333	42,143	42,143	3,163	8
9	26	Insurance-Prop./Liab./Malprac.	WeightedCensus	497,328	15	4,250	42,143	42,143	360	9
10	27	Mgmt. Allocation of Benefits	WeightedCensus	497,328	15	72,507	42,143	42,143	6,144	10
11	35	Rent-Equipment & Vehicles	WeightedCensus	497,328	15	127,935	42,143	42,143	10,841	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21		** - Please note that the 15 subunits that are being allocated among include a facility in Swansea, IL. This facility was managed from								21
22		7/1/13 thru 3/31/14. The facility units used for the Swansea facility was based on the census through 3/31/14. The Swansea facility								22
23		is not a related party.								23
24										24
25	TOTALS					\$ 1,834,563	\$ 1,501,974		\$ 155,457	25

Facility Name & ID Number Rosewood Care Ctr of Elgin

0049346 Report Period Beginning: 07/01/2013

Ending: 6/30/2014

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5**	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	497,328	15	24,339	24,339	42,143	\$ 2,062	1	
2	2	Food	497,328	15	417		42,143	35	2	
3	5	Utilities	497,328	15	2,858		42,143	242	3	
4	6	Maintenance	497,328	15	2,125		42,143	180	4	
5	7	Mgmt. Allocation of Benefits	497,328	15	2,750		42,143	233	5	
6	10	Nursing and Medical Records	497,328	15	61,958	61,958	42,143	5,250	6	
7	15	Mgmt. Allocation of Benefits	497,328	15	6,997		42,143	593	7	
8	17	Administrative	497,328	15	30,003	30,003	42,143	2,542	8	
9	19	Professional Services	497,328	15	118,742		42,143	10,062	9	
10	20	Dues, Fees, Subs & Promotions	497,328	15	20,968		42,143	1,777	10	
11	21	Clerical and General Office	497,328	15	1,344,593	1,045,674	42,143	113,943	11	
12	24	Travel and Seminar	497,328	15	40,571		42,143	3,438	12	
13	25	Other Admin. Staff Transport.	497,328	15	17,516		42,143	1,484	13	
14	26	Insurance-Prop./Liab./Malprac.	497,328	15	27,838		42,143	2,359	14	
15	27	Mgmt. Allocation of Benefits	497,328	15	121,473		42,143	10,294	15	
16	30	Depreciation	497,328	15	93,160		42,143	7,894	16	
17	32	Interest	497,328	15	6,702		42,143	568	17	
18	34	Rent-Facility and Grounds	497,328	15	83,780		42,143	7,099	18	
19	35	Rent-Equipment & Vehicles	497,328	15	17,213		42,143	1,459	19	
20									20	
21		** - Please note that the 15 subunits that are being allocated among include a facility in Swansea, IL. This facility was managed from 7/1/13 thru 3/31/14. The facility units used for the Swansea facility was based on the census through 3/31/14. The Swansea facility is not a related party.								21
22										22
23										23
24										24
25	TOTALS				\$ 2,024,003	\$ 1,161,974		\$ 171,514	25	

Facility Name & ID Number Rosewood Care Ctr of Elgin

0049346

Report Period Beginning:

07/01/2013

Ending: 6/30/2014

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5** Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
1	19	Professional Services	Weighted Census/Direct Exp 497,328	15	\$ 38,020	\$	42,143	\$ 758	1	
2	20	Dues, Fees, Subs & Promotions	Weighted Census 497,328	15	3,789		42,143	321	2	
3	21	Clerical and General Office	Weighted Census 497,328	15	183,917	183,869	42,143	15,585	3	
4	24	Travel and Seminar	Weighted Census 497,328	15	1,515		42,143	128	4	
5	25	Other Admin. Staff Transport.	Weighted Census 497,328	15	3,685		42,143	312	5	
6	26	Insurance-Prop./Liab./Malprac.	Weighted Census 497,328	15	1,930		42,143	164	6	
7	27	Mgmt. Allocation of Benefits	Weighted Census 497,328	15	17,550		42,143	1,487	7	
8	32	Interest	Weighted Census 497,328	15	957		42,143	81	8	
9									9	
10									10	
11									11	
12									12	
13									13	
14									14	
15									15	
16									16	
17									17	
18									18	
19									19	
20									20	
21		** - Please note that the 15 subunits that are being allocated among include a facility in Swansea, IL. This facility was managed from 7/1/13 thru 3/31/14. The facility units used for the Swansea facility was based on the census through 3/31/14. The Swansea facility is not a related party.								21
22										22
23										23
24										24
25	TOTALS					\$ 251,363	\$ 183,869		\$ 18,836	25

Facility Name & ID Number Rosewood Care Ctr of Elgin

0049346 Report Period Beginning: 07/01/2013

Ending: 6/30/2014

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	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	Weighted Census	15	\$ 320	\$	42,143	\$ 27	1	
2	6	Maintenance	Weighted Census/Direct Exp	15	998,295	573,323	42,143	85,735	2	
3	7	Mgmt. Allocation of Benefits	Weighted Census	15	62,296		42,143	5,279	3	
4	20	Dues, Fees, Subs & Promotions	Weighted Census	15	120		42,143	10	4	
5	21	Clerical and General Office	Weighted Census	15	9,566		42,143	811	5	
6	24	Travel and Seminar	Weighted Census	15	23,651		42,143	2,004	6	
7	25	Other Admin. Staff Transport.	Weighted Census	15	51,467		42,143	4,361	7	
8	26	Insurance-Prop./Liab./Malprac.	Weighted Census	15	14,825		42,143	1,256	8	
9	30	Depreciation	Weighted Census	15	15,975		42,143	1,354	9	
10									10	
11									11	
12									12	
13									13	
14									14	
15									15	
16									16	
17									17	
18									18	
19									19	
20									20	
21		** - Please note that the 15 subunits that are being allocated among include a facility in Swansea, IL. This facility was managed from 7/1/13 thru 3/31/14. The facility units used for the Swansea facility was based on the census through 3/31/14. The Swansea facility is not a related party.								21
22										22
23										23
24										24
25	TOTALS					\$ 1,176,515	\$ 573,323		\$ 100,837	25

Facility Name & ID Number Rosewood Care Ctr of Elgin

0049346 Report Period Beginning: 07/01/2013

Ending: 6/30/2014

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Bravo 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

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5** Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional Services	Weighted Census	497,328	15	\$ 1,400,742	\$ 42,143	\$ 118,697	1
2	21	Clerical and General Office	Weighted Census	497,328	15	6,337	42,143	537	2
3	24	Travel and Seminar	Weighted Census	497,328	15	913	42,143	78	3
4	26	Insurance-Prop./Liab./Malprac.	Weighted Census	497,328	15	6,835	42,143	579	4
5	32	Interest	Weighted Census	497,328	15	235,278	42,143	19,937	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21	** - Please note that the 15 subunits that are being allocated among include a facility in Swansea, IL. This facility was managed from								
22	7/1/13 thru 3/31/14. The facility units used for the Swansea facility was based on the census through 3/31/14. The Swansea facility								
23	is not a related party.								
24									24
25	TOTALS					\$ 1,650,105	\$	\$ 139,828	25

Facility Name & ID Number

Rosewood Care Ctr of Elgin

0049346

Report Period Beginning:

07/01/2013

Ending:

06/30/2014

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10	Reporting Period Interest Expense				
		Related**					Monthly Payment Required	Date of Note					Amount of Note		Maturity Date	Interest Rate (4 Digits)
		YES	NO										Original	Balance		
	A. Directly Facility Related															
	Long-Term															
1	Berkadia		X	Mortgage	\$72,580.21	8/1/04	\$ 5,558,983	\$ 14,001,654	9/1/39	0.0239	\$ 168,009	1				
2												2				
3												3				
4												4				
5												5				
	Working Capital															
6	MidCap (Thru Allocation of		X	Revolving Line of Credit		8/1/09			12/31/14	5.0000	19,937	6				
7	Bravo Holding Co.)											7				
8												8				
9	TOTAL Facility Related				\$72,580.21		\$ 5,558,983	\$ 14,001,654			\$ 187,946	9				
	B. Non-Facility Related*															
10							Less: Interest Income Offset				(27,367)	10				
11							Amortization Expense				3,044	11				
12							Allocated from Mgmt Co's				649	12				
13												13				
14	TOTAL Non-Facility Related						\$	\$			\$ (23,674)	14				
15	TOTALS (line 9+line14)						\$ 5,558,983	\$ 14,001,654			\$ 164,272	15				

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 35,263 Line # 26

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.													
1. Real Estate Tax accrual used on 2013 report.				\$	110,543										
					1										
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	See Below			\$	105,216										
					2										
3. Under or (over) accrual (line 2 minus line 1).				\$	(5,327)										
					3										
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	103,004										
					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										
			Less: Expense from 7/1/13 to 12/31/13 (Pre-Acquisition-See Att Sch I)		(55,817)										
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.				\$	41,860										
					7										
Real Estate Tax History:															
Real Estate Tax Bill for Calendar Year:	2009	112,060	8	<table border="1"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2013 \$</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2013 \$	14	PLUS APPEAL COST FROM LINE 5 \$	15	LESS REFUND FROM LINE 6 \$	16	AMOUNT TO USE FOR RATE CALCULATION \$
FOR BHF USE ONLY															
13	FROM R. E. TAX STATEMENT FOR 2013 \$														
14	PLUS APPEAL COST FROM LINE 5 \$														
15	LESS REFUND FROM LINE 6 \$														
16	AMOUNT TO USE FOR RATE CALCULATION \$														
Taxes Paid-2012	2010	116,098	9												
Taxes Paid-2013	2011	110,779	10												
Total Taxes Paid	2012	109,448	11												
	2013	100,985	12												
<u>Accrual based on prior year tax bill.</u>															
<u>Note: The real estate entity was purchased on 12/31/13, therefore the beginning accrual used above reflects the accrued real estate tax balance as of 6/30/13 in order for the worksheet to compute properly.</u>															
<u>See explanation on Att Sch I</u>															

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rosewood Care Ctr of Elgin COUNTY Kane
 FACILITY IDPH LICENSE NUMBER 0049346
 CONTACT PERSON REGARDING THIS REPORT Mary Offner
 TELEPHONE (314) 994-9070 FAX #: (314) 994-9912

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>06-09-100-021</u>	<u>2355 Royal BLVD</u>	\$ <u>100,984.72</u>	\$ <u>100,984.72</u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u><u>100,984.72</u></u>	\$ <u><u>100,984.72</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,268 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

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

None

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

1. Total Amount Incurred: _____ 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	<u>Nursing Home</u>	<u>206,817</u>	<u>2013</u>	<u>\$ 590,758</u>	1
2					2
3	TOTALS	206,817		\$ 590,758	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4	139	2013	\$ 2,778,942	\$	40	\$ 34,737	\$ 34,737	\$ 34,737	4	
5									5	
6									6	
7									7	
8									8	
Improvement Type**										
9	Building Improvements - Real Estate Entity									9
10									10	
11	Boiler Replacement	2013	2,954		40	43	43	43	11	
12	Drain Piping	2014	3,989		40	42	42	42	12	
13	Cat Iron Drain	2014	3,324		40	35	35	35	13	
14	HVAC Improvements	2014	5,310		10	266	266	266	14	
15	Sprinkler	2014	47,526		10	396	396	396	15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25									25	
26									26	
27									27	
28									28	
29									29	
30									30	
31									31	
32									32	
33									33	
34									34	
35									35	
36									36	

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Rosewood Care Ctr of Elgin

0049346

Report Period Beginning:

07/01/2013

Ending:

06/30/2014

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39	2008	4,131	590	7	590		3,738	39
40	2009	7,053	1,008	7	1,008		5,542	40
41	2008	3,350	479	7	479		2,871	41
42	2009	2,785	398	7	398		1,824	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								67
68								68
69								69
70		\$ 2,859,364	\$ 2,475		\$ 37,994	\$ 35,519	\$ 49,494	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 50,495	\$ 9,961	\$ 9,961	\$	5	\$ 14,114	71
72	Current Year Purchases	5,712	854	854		5	854	72
73	Fully Depreciated Assets							73
74	Allocated from Mgmt Co/Real Estate Entity	229,463		20,721	20,721	10	11,473	74
75	TOTALS	\$ 285,670	\$ 10,815	\$ 31,536	\$ 20,721		\$ 26,441	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,735,792	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 13,290	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 69,530	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 56,240	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 75,935	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	95

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

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

Facility Name & ID Number Rosewood Care Ctr of Elgin

0049346

Report Period Beginning: 07/01/2013

Ending: 06/30/2014

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Elgin Real Estate, L.L.C.

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1994</u>	<u>139</u>	<u>12/1/07</u>	\$ <u>834,064</u>	<u>5</u>	<u>Unlimited</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		<u>139</u>		\$ <u>834,064</u>			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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

This amount was calculated by dividing the total amount to be amortized

by the length of the lease N/A.

N/A

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 30,493 Description: Medical Equipment \$17,060; Offsite Storage \$1,133, Home Office Allocation - \$12,300

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>N/A</u>		\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

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

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

Facility Name & ID Number Rosewood Care Ctr of Elgin # 0049346 Report Period Beginning: 07/01/2013 Ending: 06/30/2014
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	10,044	\$ 412,589	\$	10,044	\$ 412,589	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,629	119,460		2,629	119,460	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		10,553	443,435	4,062	10,553	447,497	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				409,133		409,133	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	23,226	\$ 975,484	\$ 413,195	23,226	\$ 1,388,679	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Rosewood Care Ctr of Elgin

0049346

Report Period Beginning: 07/01/2013

Ending: 06/30/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2014 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 7,930	\$ 136,747	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>224,585</u>)	2,022,764	2,022,764	3
4	Supply Inventory (priced at <u>Cost</u>)	4,283	4,283	4
5	Short-Term Investments			5
6	Prepaid Insurance	30,748	33,448	6
7	Other Prepaid Expenses	3,978	3,978	7
8	Accounts Receivable (owners or related parties)	2,140,127	2,249,672	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,209,830	\$ 4,450,892	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		590,758	13
14	Buildings, at Historical Cost		2,778,942	14
15	Leasehold Improvements, at Historical Cost	17,319	80,422	15
16	Equipment, at Historical Cost	56,207	285,670	16
17	Accumulated Depreciation (book methods)	(28,943)	(75,935)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		491,897	21
22	Other Long-Term Assets (spec <u>Loan Fees</u>)		188,622	22
23	Other(specify): <u>Deposits</u>	2,000	2,000	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 46,583	\$ 4,342,376	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,256,413	\$ 8,793,268	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 818,683	\$ 930,858	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	397,117	397,117	30
31	Accrued Taxes Payable (excluding real estate taxes)	32,063	32,063	31
32	Accrued Real Estate Taxes(Sch.IX-B)		103,004	32
33	Accrued Interest Payable		33,764	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	9,212	9,212	35
Other Current Liabilities(specify):				
36	<u>Accrued Expenses</u>	320,880	325,006	36
37	<u>Accrued Rent</u>	723,408		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,301,363	\$ 1,831,024	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		14,001,654	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)	\$	\$ 14,001,654	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,301,363	\$ 15,832,678	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,955,050	\$ (7,039,410)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,256,413	\$ 8,793,268	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,209,488	1
2	Restatements (describe):		2
3	Prior Period Adjustment	(42,000)	3
4	Rounding	(1)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,167,487	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	787,563	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)	\$ 787,563	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)	\$ 1,955,050	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	\$ 13,137,235	1
2	Discounts and Allowances for all Levels	(2,824,910)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,312,325	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	304,837	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 304,837	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	2,400	13
14	Non-Patient Meals	4,313	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	80,124	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 86,837	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	77,254	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 77,254	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Attached Schedule</u>	3,424	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,424	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,784,677	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,317,192	31
32	Health Care	4,722,441	32
33	General Administration	1,421,643	33
B. Capital Expense			
34	Ownership	1,459,013	34
C. Ancillary Expense			
35	Special Cost Centers	803,866	35
36	Provider Participation Fee	272,959	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,997,114	40
41	Income before Income Taxes (line 30 minus line 40)**	787,563	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 787,563	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,102,441	44
45	Private Pay - Net Inpatient Revenue	3,344,038	45
46	Medicare - Net Inpatient Revenue	4,455,425	46
47	Other-(specify) <u>Insurance</u>	410,421	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 10,312,325	49

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

** Does this agree with taxable income (loss) per Federal Income

Tax Return? Not complete If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Rosewood Care Ctr of Elgin

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

Schedule 19A

Other Revenue:

Vending Income	729
Vendor Discount	1,567
Miscellaneous	1,128
	<hr/>
Total Other Revenue	<u>3,424</u>

Facility Name & ID Number Rosewood Care Ctr of Elgin

0049346

Report Period Beginning: 07/01/2013

Ending: 06/30/2014

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,109	2,281	\$ 98,904	\$ 43.36	1
2	Assistant Director of Nursing	2,176	2,480	87,689	35.36	2
3	Registered Nurses	33,337	36,140	1,045,293	28.92	3
4	Licensed Practical Nurses	17,505	19,133	424,485	22.19	4
5	CNAs & Orderlies	87,381	92,768	1,110,791	11.97	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,993	4,672	53,931	11.54	8
9	Activity Director	2,088	2,259	32,513	14.39	9
10	Activity Assistants	3,086	3,263	27,623	8.47	10
11	Social Service Workers	5,059	5,625	87,714	15.59	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,077	24,721	250,678	10.14	15
16	Dishwashers					16
17	Maintenance Workers	2,285	2,456	34,051	13.86	17
18	Housekeepers	19,173	20,534	172,159	8.38	18
19	Laundry	2,806	2,954	37,918	12.84	19
20	Administrator	2,158	2,374	91,967	38.74	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,140	9,769	130,054	13.31	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	2,155	2,302	50,731	22.04	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Sch 20A</u>	21,131	22,962	544,840	23.73	33
34	TOTAL (lines 1 - 33)	238,659	256,693	\$ 4,281,341 *	\$ 16.68	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	\$ 18,437	L1, C3	35
36	Medical Director	Monthly	12,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,863	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,600	L11, C3	44
45	Social Service Consultant	Monthly	2,600	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 42,500		49

C. CONTRACT NURSES

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

Rosewood Care Ctr of Elgin

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

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Nurse	2,834	3,019	125,187	41.47
Case Manager	3,714	4,101	131,215	32.00
Rehabilitation Nurse	4,428	4,876	117,358	24.07
Ward Clerk	4,503	4,861	74,338	15.29
Marketing	5,652	6,105	96,742	15.85
TOTAL	<u>21,131</u>	<u>22,962</u>	<u>544,840</u>	

Facility Name & ID Number Rosewood Care Ctr of Elgin

0049346

Report Period Beginning: 07/01/2013

Ending: 06/30/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Peggy Aschenbrenner</u>	<u>Administrator</u>	<u>0</u>	<u>\$ 91,967</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 113,056</u>	<u>IDPH License Fee</u>	<u>\$</u>	
				<u>Unemployment Compensation Insurance</u>	<u>53,497</u>	<u>Advertising: Employee Recruitment</u>	<u>1,535</u>	
				<u>FICA Taxes</u>	<u>322,890</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>39,022</u>	<u>(Indicate # of checks performed)</u>	<u>3,294</u>	
				<u>Employee Meals</u>		<u>Patient Background Checks</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Misc. Dues/Subscriptions/Fees</u>	<u>550</u>	
				<u>Employee Relations</u>	<u>3,491</u>	<u>Rosewood License Fee</u>	<u>1,500</u>	
				<u>Employee Uniforms</u>	<u>1,049</u>	<u>IHCA Dues</u>	<u>4,902</u>	
				<u>Employee Physicals</u>	<u>2,465</u>	<u>Misc. Licenses & Fees</u>	<u>1,320</u>	
				<u>Employee Drug Tests</u>	<u>35</u>	<u>Home Office Allocation</u>	<u>2,121</u>	
				<u>Tuition Reimbursement</u>	<u>660</u>	<u>Less: Public Relations Expense</u>	<u>()</u>	
						<u>Non-allowable advertising</u>	<u>()</u>	
						<u>Yellow page advertising</u>	<u>()</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 91,967	TOTAL (agree to Schedule V,	\$ 536,165	TOTAL (agree to Sch. V,	\$ 15,222	
(List each licensed administrator separately.)				line 22, col.8)		line 20, col. 8)		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description				Description			Description	
Amount				Line #			Amount	
<u>Mgmt Fees-Bravo Nursing Home Svc-See Page 6, Elimon P 3, C 7</u>			<u>\$ 138,000</u>	<u>N/A</u>			<u>Out-of-State Travel</u>	<u>\$</u>
<u>Mgmt Fees-Midwest Admin Svc-See Page 6, Elimon P 3, C 7</u>								
<u>from 1/1/14-6/30/14 (post-acquisition)</u>			<u>170,024</u>				<u>In-State Travel</u>	
							<u>Home Office Allocation</u>	<u>7,741</u>
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 308,024	TOTAL			<u>Seminar Expense</u>	<u>403</u>
(Attach a copy of any management service agreement)								
C. Professional Services				F. Dues, Fees, Subscriptions and Promotions			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description			Description	
<u>Hochschild, Bloom & Company</u>	<u>Accountant/Consultant</u>		<u>\$ 3,394</u>				Amount	
<u>Midwest Administrative Services</u>	<u>Administrative/Bookkeeping</u>		<u>166,534</u>				<u>Out-of-State Travel</u>	
<u>Claims Administration Services, Inc.</u>	<u>Related Party Legal Fees</u>		<u>13,743</u>					
<u>Daniel Maher</u>	<u>Allowable Legal Fees</u>		<u>6,684</u>				<u>In-State Travel</u>	
<u>Mulherin, Rehfeldt & Varchetto</u>	<u>Allowable Legal Fees</u>		<u>4,999</u>				<u>Home Office Allocation</u>	
<u>Amy Ostrolenk</u>	<u>Medical Records Review</u>		<u>750</u>					
<u>Litchfield Cavo LLP</u>	<u>Deposition Fees</u>		<u>10,817</u>					
<u>CJ Schlosser & Co.</u>	<u>Accountant/Consultant</u>		<u>50</u>				<u>Seminar Expense</u>	
<u>ElderCare Decisions</u>	<u>Gerontologic Specialist</u>		<u>4,442</u>					
<u>Healthcare Horizons, LTD</u>	<u>Healthcare Consultant</u>		<u>1,135</u>					
<u>Janson Reporting Services</u>	<u>Transcript Fees</u>		<u>813</u>					
<u>See Attached Schedule</u>			<u>7,752</u>					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 221,113				<u>Entertainment Expense</u>	
(For legal fee disclosure, see page 39 of instructions)							<u>(agree to Sch. V,</u>	

* Attach copy of IMRF notifications

**See instructions.

Rosewood Care Ctr of Elgin

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

Schedule 21A

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Senior Care Capital	Closing Fees	7,500
Sun Times Medica	Public Notice	52
US Managed Care Services, LLC	Managed Care Consultant	200
	Total	<u>7,752</u>

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

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

Facility Name & ID Number Rosewood Care Ctr of Elgin# 0049346Report Period Beginning: 07/01/2013Ending: 06/30/2014**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. 4,902 IHCA
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 65,559 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 272,959
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 5,042
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.