FOR BHF USE

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

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

I. IDPH License ID Number: 0049270

Facility Name: Rosewood Care Ctr of Rckford

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

County: Winnebago

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Larry Templin **Telephone Number:** (630) 361-2868
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 07/01/2013 to 06/30/2014 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) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, P.O. Box 9, Dunlap, IL 61525
(Telephone) (630) 361-2868 Fax # ( )

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 Ctr of Rckford # 0049270 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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		3,598	7,354	10,952	8
9	SNF/PED					9
10	ICF	16,376	3,282		19,658	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,376	6,880	7,354	30,610	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.89%

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 [X] 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 [X]

I. On what date did you start providing long term care at this location?
Date started 12/1/07

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/1/07 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 58 and days of care provided 6,168

Medicare Intermediary Novitas Solutions, Inc.

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Rosewood Care Ctr of Rckford # 0049270 **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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	243,321	21,104	14,558	278,983		278,983	1,498	280,481			1
2	Food Purchase		209,952		209,952		209,952	(7,849)	202,103			2
3	Housekeeping	146,672	27,105		173,777		173,777		173,777			3
4	Laundry	47,019	15,614		62,633		62,633		62,633			4
5	Heat and Other Utilities			121,704	121,704		121,704	196	121,900			5
6	Maintenance	14,415	10,329	187,712	212,456		212,456	(31,138)	181,318			6
7	Other (specify):* Allocated HO Benefits							4,003	4,003			7
8	**TOTAL General Services**	451,427	284,104	323,974	1,059,505		1,059,505	(33,290)	1,026,215			8
	B. Health Care and Programs											
9	Medical Director			8,250	8,250		8,250		8,250			9
10	Nursing and Medical Records	2,512,707	216,152	87,806	2,816,665		2,816,665	41,438	2,858,103			10
10a	Therapy		1,537	743,916	745,453		745,453		745,453			10a
11	Activities	61,059	4,613	2,100	67,772		67,772		67,772			11
12	Social Services	56,577		2,100	58,677		58,677		58,677			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Allocated HO Benefits							3,494	3,494			15
16	**TOTAL Health Care and Programs**	2,630,343	222,302	844,172	3,696,817		3,696,817	44,932	3,741,749			16
	C. General Administration											
17	Administrative	92,624		243,854	336,478		336,478	(229,273)	107,205			17
18	Directors Fees											18
19	Professional Services			143,478	143,478		143,478	84,292	227,770			19
20	Dues, Fees, Subscriptions & Promotions			21,724	21,724		21,724	(1,096)	20,628			20
21	Clerical & General Office Expenses	109,992	16,963	40,552	167,507		167,507	138,717	306,224			21
22	Employee Benefits & Payroll Taxes			441,439	441,439		441,439		441,439			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,176	1,176		1,176	5,622	6,798			24
25	Other Admin. Staff Transportation			4,624	4,624		4,624	4,336	8,960			25
26	Insurance-Prop.Liab.Malpractice			51,253	51,253		51,253	32,587	83,840			26
27	Other (specify):* Allocated HO Benefits							13,020	13,020			27
28	**TOTAL General Administration**	202,616	16,963	948,100	1,167,679		1,167,679	48,205	1,215,884			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,284,386	523,369	2,116,246	5,924,001		5,924,001	59,847	5,983,848			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 Rckford #0049270 **Report Period Beginning:** 07/01/2013 **Ending:** 06/30/2014

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger										
	Capital Expense	Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			13,753	13,753		13,753	42,270	56,023			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			131,701	131,701		131,701	92,166	223,867			32
33	Real Estate Taxes			60,360	60,360		60,360	63,375	123,735			33
34	Rent-Facility & Grounds			919,174	919,174		919,174	(460,515)	458,659			34
35	Rent-Equipment & Vehicles			69,672	69,672		69,672	8,933	78,605			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,194,660	1,194,660		1,194,660	(253,771)	940,889			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		262,821		262,821		262,821		262,821			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			215,204	215,204		215,204		215,204			42
43	Other (specify):* See Page 4A	77,858		337,309	415,167		415,167	(390,965)	24,202			43
44	**TOTAL Special Cost Centers**	77,858	262,821	552,513	893,192		893,192	(390,965)	502,227			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,362,244	786,190	3,863,419	8,011,853		8,011,853	(584,889)	7,426,964			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 Rckford

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

Schedule 4A

V. Cost Center Expenses

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
		1	2	3	4	5	6	7	8	9	10	
	Ancillary Expense											
	E. Special Cost Centers											
43	Other (specify):*				0		0		0			
	Laboratory Expense			8,862	8,862		8,862		8,862			
	Radiology Expenses			15,340	15,340		15,340		15,340			
	Non-Allowable Expenses	77,858		313,107	390,965		390,965	(390,965)	0			
					0		0		0			
					0		0		0			
	TOTAL Other Special Cost Centers	77,858	0	337,309	415,167	0	415,167	(390,965)	24,202			

Facility Name & ID Number Rosewood Care Ctr of Rckford # 0049270 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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,271)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,127)	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	(48,247)	30		9
10	Interest and Other Investment Income	(26,552)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,604)	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	(2,637)	20		17
18	Fines and Penalties				18
19	Entertainment	(8)	43		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(18,300)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(303,998)	43		24
25	Fund Raising, Advertising and Promotional	(2,669)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(230)	43		28
29	Other-Attach Schedule See Page 5A	(80,894)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (497,537)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(87,352)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (87,352)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (584,889)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		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

STATE OF ILLINOIS **Page 5A**

Rosewood Care Ctr of Rckford

ID# **0049270**

Report Period Beginning: **07/01/2013**

Ending: **06/30/2014**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate Marketing Salary	$ (77,858)	43	1
2	Miscellaneous Income Offset	(526)	21	2
3	Disallow Resident Reimbursement	(75)	43	3
4	Disallow Marketing Mileage Reimbursement	(2,435)	25	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
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23				23
24				24
25				25
26				26
27				27
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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**	(80,894)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Ctr of Rckford **#** 0049270 **Report Period Beginning:** 07/01/2013 **Ending:** 06/30/2014

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	1,498	0	0	0	0	0	0	0	0	1,498	1
2	Food Purchase	(7,875)	0	26	0	0	0	0	0	0	0	0	(7,849)	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	176	0	20	0	0	0	0	0	0	196	5
6	Maintenance	0	0	131	0	(31,269)	0	0	0	0	0	0	(31,138)	6
7	Other (specify):*	0	0	169	0	3,834	0	0	0	0	0	0	4,003	7
8	**TOTAL General Services**	(7,875)	0	2,000	0	(27,415)	0	0	0	0	0	0	(33,290)	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	37,625	3,813	0	0	0	0	0	0	0	0	41,438	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	3,063	431	0	0	0	0	0	0	0	0	3,494	15
16	**TOTAL Health Care and Programs**	0	40,688	4,244	0	0	0	0	0	0	0	0	44,932	16
	C. General Administration													
17	Administrative	0	(125,266)	(107,607)	0	0	0	3,600	0	0	0	0	(229,273)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(18,300)	96	7,308	6,726	0	86,214	2,248	0	0	0	0	84,292	19
20	Fees, Subscriptions & Promotions	(2,637)	10	1,291	233	7	0	0	0	0	0	0	(1,096)	20
21	Clerical & General Office Expenses	(526)	42,971	82,758	11,320	589	390	1,215	0	0	0	0	138,717	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,520	2,497	93	1,456	56	0	0	0	0	0	5,622	24
25	Other Admin. Staff Transportation	(2,435)	2,298	1,078	227	3,168	0	0	0	0	0	0	4,336	25
26	Insurance-Prop.Liab.Malpractice	0	261	1,713	119	912	421	29,161	0	0	0	0	32,587	26
27	Other (specify):*	0	4,463	7,477	1,080	0	0	0	0	0	0	0	13,020	27
28	**TOTAL General Administration**	(23,898)	(73,647)	(3,485)	19,798	6,132	87,081	36,224	0	0	0	0	48,205	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(31,773)	(32,959)	2,759	19,798	(21,283)	87,081	36,224	0	0	0	0	59,847	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Ctr of Rckford # 0049270 **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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(48,247)	0	5,734	0	983	0	83,800	0	0	0	0	42,270	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(26,552)	0	413	59	0	(117,220)	235,466	0	0	0	0	92,166	32
33	Real Estate Taxes	0	0	0	0	0	0	63,375	0	0	0	0	63,375	33
34	Rent-Facility & Grounds	0	0	5,157	0	0	0	(465,672)	0	0	0	0	(460,515)	34
35	Rent-Equipment & Vehicles	0	7,874	1,059	0	0	0	0	0	0	0	0	8,933	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(74,799)	7,874	12,363	59	983	(117,220)	(83,031)	0	0	0	0	(253,771)	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):*	(390,965)	0	0	0	0	0	0	0	0	0	0	(390,965)	43
44	TOTAL Special Cost Centers	(390,965)	0	0	0	0	0	0	0	0	0	0	(390,965)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(497,537)	(25,085)	15,122	19,857	(20,300)	(30,139)	(46,807)	0	0	0	0	(584,889)	45

Facility Name & ID Number Rosewood Care Ctr of Rckford # 0049270 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

VII. RELATED PARTIES

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

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

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

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

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	Nursing & Medical Records	$	Bravo Nursing Home Services, Inc.	0.00%	$ 37,625	$ 37,625	1
2	V	15	Mgmt. Allocation of Benefits		Bravo Nursing Home Services, Inc.	0.00%	3,063	3,063	2
3	V	17	Mgmt Fee/Administrative	138,000	Bravo Nursing Home Services, Inc.	0.00%	12,734	(125,266)	3
4	V	19	Professional Services		Bravo Nursing Home Services, Inc.	0.00%	96	96	4
5	V	20	Dues, Fees, Subs & Promotions		Bravo Nursing Home Services, Inc.	0.00%	10	10	5
6	V	21	Clerical and General Office		Bravo Nursing Home Services, Inc.	0.00%	42,971	42,971	6
7	V	24	Travel and Seminar		Bravo Nursing Home Services, Inc.	0.00%	1,520	1,520	7
8	V	25	Other Admin. Staff Transport.		Bravo Nursing Home Services, Inc.	0.00%	2,298	2,298	8
9	V	26	Insurance-Prop./Liab./Malprac.		Bravo Nursing Home Services, Inc.	0.00%	261	261	9
10	V	27	Mgmt. Allocation of Benefits		Bravo Nursing Home Services, Inc.	0.00%	4,463	4,463	10
11	V	35	Rent-Equipment & Vehicles		Bravo Nursing Home Services, Inc.	0.00%	7,874	7,874	11
12	V								12
13	V								13
14	Total			$ 138,000			$ 112,915	$ * (25,085)	14

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

Facility Name & ID Number Rosewood Care Ctr of Rckford # 0049270 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Midwest Administrative Services, Inc.	0.00%	$ 1,498	$ 1,498	15
16	V	2	Food		Midwest Administrative Services, Inc.	0.00%	26	26	16
17	V	5	Utilities		Midwest Administrative Services, Inc.	0.00%	176	176	17
18	V	6	Maintenance		Midwest Administrative Services, Inc.	0.00%	131	131	18
19	V	7	Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	169	169	19
20	V	10	Nursing and Medical Records		Midwest Administrative Services, Inc.	0.00%	3,813	3,813	20
21	V	15	Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	431	431	21
22	V	17	Mgmt Fee/Administrative	109,454	Midwest Administrative Services, Inc.	0.00%	1,847	(107,607)	22
23	V	19	Professional Services		Midwest Administrative Services, Inc.	0.00%	7,308	7,308	23
24	V	20	Dues, Fees, Subs & Promotions		Midwest Administrative Services, Inc.	0.00%	1,291	1,291	24
25	V	21	Clerical and General Office		Midwest Administrative Services, Inc.	0.00%	82,758	82,758	25
26	V	24	Travel and Seminar		Midwest Administrative Services, Inc.	0.00%	2,497	2,497	26
27	V	25	Other Admin. Staff Transport.		Midwest Administrative Services, Inc.	0.00%	1,078	1,078	27
28	V	26	Insurance-Prop./Liab./Malprac.		Midwest Administrative Services, Inc.	0.00%	1,713	1,713	28
29	V	27	Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	7,477	7,477	29
30	V	30	Depreciation		Midwest Administrative Services, Inc.	0.00%	5,734	5,734	30
31	V	32	Interest		Midwest Administrative Services, Inc.	0.00%	413	413	31
32	V	34	Rent-Facility and Grounds		Midwest Administrative Services, Inc.	0.00%	5,157	5,157	32
33	V	35	Rent-Equipment & Vehicles		Midwest Administrative Services, Inc.	0.00%	1,059	1,059	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 109,454			$ 124,576	$ * 15,122	39

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

Facility Name & ID Number Rosewood Care Ctr of Rckford # 0049270 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Services	$ 5,533	Claims Administration Services, LLC	0.00%	$ 12,259	$ 6,726	15
16	V	20	Dues, Fees, Subs & Promotions		Claims Administration Services, LLC	0.00%	233	233	16
17	V	21	Clerical and General Office		Claims Administration Services, LLC	0.00%	11,320	11,320	17
18	V	24	Travel and Seminar		Claims Administration Services, LLC	0.00%	93	93	18
19	V	25	Other Admin. Staff Transport.		Claims Administration Services, LLC	0.00%	227	227	19
20	V	26	Insurance-Prop./Liab./Malprac.		Claims Administration Services, LLC	0.00%	119	119	20
21	V	27	Mgmt. Allocation of Benefits		Claims Administration Services, LLC	0.00%	1,080	1,080	21
22	V	32	Interest		Claims Administration Services, LLC	0.00%	59	59	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			$ 5,533			$ 25,390	$ * 19,857	39

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

Facility Name & ID Number Rosewood Care Ctr of Rckford # 0049270 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	Senior Living Services, Inc.	0.00%	$ 20	$ 20	15
16	V	6	Maintenance	97,099	Senior Living Services, Inc.	0.00%	65,830	(31,269)	16
17	V	7	Mgmt. Allocation of Benefits		Senior Living Services, Inc.	0.00%	3,834	3,834	17
18	V	20	Dues, Fees, Subs & Promotions		Senior Living Services, Inc.	0.00%	7	7	18
19	V	21	Clerical and General Office		Senior Living Services, Inc.	0.00%	589	589	19
20	V	24	Travel and Seminar		Senior Living Services, Inc.	0.00%	1,456	1,456	20
21	V	25	Other Admin. Staff Transport.		Senior Living Services, Inc.	0.00%	3,168	3,168	21
22	V	26	Insurance-Prop./Liab./Malprac.		Senior Living Services, Inc.	0.00%	912	912	22
23	V	30	Depreciation		Senior Living Services, Inc.	0.00%	983	983	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			$ 97,099			$ 76,799	$ * (20,300)	39

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

Facility Name & ID Number Rosewood Care Ctr of Rckford # 0049270 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Services	$	Bravo Holding Company	0.00%	$ 86,214	$ 86,214	15
16	V	21	Clerical and General Office		Bravo Holding Company	0.00%	390	390	16
17	V	24	Travel and Seminar		Bravo Holding Company	0.00%	56	56	17
18	V	26	Insurance-Prop./Liab./Malprac.		Bravo Holding Company	0.00%	421	421	18
19	V	32	Interest	131,701	Bravo Holding Company	0.00%	14,481	(117,220)	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			$ 131,701			$ 101,562	$ * (30,139)	39

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

Facility Name & ID Number Rosewood Care Ctr of Rckford # 0049270 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Administrative	$	Rockford Real Estate, LLC	0.00%	$ 3,600	$ 3,600	15
16	V	19	Professional Services		Rockford Real Estate, LLC	0.00%	2,248	2,248	16
17	V	21	Clerical and General Office		Rockford Real Estate, LLC	0.00%	1,215	1,215	17
18	V	26	Insurance-Prop./Liab./Malprac.		Rockford Real Estate, LLC	0.00%	29,161	29,161	18
19	V	30	Depreciation		Rockford Real Estate, LLC	0.00%	83,800	83,800	19
20	V	32	Interest		Rockford Real Estate, LLC	0.00%	235,466	235,466	20
21	V	33	Real Estate Taxes		Rockford Real Estate, LLC	0.00%	63,375	63,375	21
22	V	34	Rent-Facility and Grounds	465,672	Rockford Real Estate, LLC	0.00%		(465,672)	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			$ 465,672			$ 418,865	$ * (46,807)	39

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

Facility Name & ID Number Rosewood Care Ctr of Rckford # 0049270 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

VII. RELATED PARTIES

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

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

Facility Name & ID Number Rosewood Care Ctr of Rckford # 0049270 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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Michael Brady	President (Note 1)	Administrative	0.00	97,076	3.08	6.16	Salary	$ 6,367	L17, C7	1
2	Mark Yampol	CEO (Note 2)	Administrative	0.00	28,155	3.08	6.16	Salary	1,847	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	$ 8,214		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 Rckford # 0049270 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 [X] NO [ ]

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

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

	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	30,610	$ 37,625	1
2	15	Mgmt. Allocation of Benefits	WeightedCensus	497,328	15	49,766		30,610	3,063	2
3	17	Administrative	WeightedCensus	497,328	15	206,886	206,886	30,610	12,734	3
4	19	Professional Services	WeightedCensus	497,328	15	1,560		30,610	96	4
5	20	Dues, Fees, Subs & Promotions	WeightedCensus	497,328	15	155		30,610	10	5
6	21	Clerical and General Office	WeightedCensus	497,328	15	698,165	683,784	30,610	42,971	6
7	24	Travel and Seminar	WeightedCensus	497,328	15	24,702		30,610	1,520	7
8	25	Other Admin. Staff Transport.	WeightedCensus	497,328	15	37,333		30,610	2,298	8
9	26	Insurance-Prop./Liab./Malprac.	WeightedCensus	497,328	15	4,250		30,610	261	9
10	27	Mgmt. Allocation of Benefits	WeightedCensus	497,328	15	72,507		30,610	4,463	10
11	35	Rent-Equipment & Vehicles	WeightedCensus	497,328	15	127,935		30,610	7,874	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		$ 112,915	25

Facility Name & ID Number Rosewood Care Ctr of Rckford # 0049270 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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5** Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	WeightedCensus	497,328	15	24,339	24,339	30,610	$ 1,498	1
2	2	Food	WeightedCensus	497,328	15	417		30,610	26	2
3	5	Utilities	WeightedCensus	497,328	15	2,858		30,610	176	3
4	6	Maintenance	WeightedCensus	497,328	15	2,125		30,610	131	4
5	7	Mgmt. Allocation of Benefits	WeightedCensus	497,328	15	2,750		30,610	169	5
6	10	Nursing and Medical Records	WeightedCensus	497,328	15	61,958	61,958	30,610	3,813	6
7	15	Mgmt. Allocation of Benefits	WeightedCensus	497,328	15	6,997		30,610	431	7
8	17	Administrative	WeightedCensus	497,328	15	30,003	30,003	30,610	1,847	8
9	19	Professional Services	WeightedCensus	497,328	15	118,742		30,610	7,308	9
10	20	Dues, Fees, Subs & Promotions	WeightedCensus	497,328	15	20,968		30,610	1,291	10
11	21	Clerical and General Office	WeightedCensus	497,328	15	1,344,593	1,045,674	30,610	82,758	11
12	24	Travel and Seminar	WeightedCensus	497,328	15	40,571		30,610	2,497	12
13	25	Other Admin. Staff Transport.	WeightedCensus	497,328	15	17,516		30,610	1,078	13
14	26	Insurance-Prop./Liab./Malprac.	WeightedCensus	497,328	15	27,838		30,610	1,713	14
15	27	Mgmt. Allocation of Benefits	WeightedCensus	497,328	15	121,473		30,610	7,477	15
16	30	Depreciation	WeightedCensus	497,328	15	93,160		30,610	5,734	16
17	32	Interest	WeightedCensus	497,328	15	6,702		30,610	413	17
18	34	Rent-Facility and Grounds	WeightedCensus	497,328	15	83,780		30,610	5,157	18
19	35	Rent-Equipment & Vehicles	WeightedCensus	497,328	15	17,213		30,610	1,059	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					$ 2,024,003	$ 1,161,974		$ 124,576	25

Facility Name & ID Number Rosewood Care Ctr of Rckford # 0049270 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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5** Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional Services	WeightedCensus/Direct Exp	497,328	15	$ 38,020	$	30,610	$ 12,259	1
2	20	Dues, Fees, Subs & Promotions	WeightedCensus	497,328	15	3,789		30,610	233	2
3	21	Clerical and General Office	WeightedCensus	497,328	15	183,917	183,869	30,610	11,320	3
4	24	Travel and Seminar	WeightedCensus	497,328	15	1,515		30,610	93	4
5	25	Other Admin. Staff Transport.	WeightedCensus	497,328	15	3,685		30,610	227	5
6	26	Insurance-Prop./Liab./Malprac.	WeightedCensus	497,328	15	1,930		30,610	119	6
7	27	Mgmt. Allocation of Benefits	WeightedCensus	497,328	15	17,550		30,610	1,080	7
8	32	Interest	WeightedCensus	497,328	15	957		30,610	59	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								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					$ 251,363	$ 183,869		$ 25,390	25

Facility Name & ID Number Rosewood Care Ctr of Rckford # 0049270 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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5** Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	WeightedCensus	497,328	15	$ 320	$	30,610	$ 20	1
2	6	Maintenance	WeightedCensus/Direct Exp	497,328	15	998,295	573,323	30,610	65,830	2
3	7	Mgmt. Allocation of Benefits	WeightedCensus	497,328	15	62,296		30,610	3,834	3
4	20	Dues, Fees, Subs & Promotions	WeightedCensus	497,328	15	120		30,610	7	4
5	21	Clerical and General Office	WeightedCensus	497,328	15	9,566		30,610	589	5
6	24	Travel and Seminar	WeightedCensus	497,328	15	23,651		30,610	1,456	6
7	25	Other Admin. Staff Transport.	WeightedCensus	497,328	15	51,467		30,610	3,168	7
8	26	Insurance-Prop./Liab./Malprac.	WeightedCensus	497,328	15	14,825		30,610	912	8
9	30	Depreciation	WeightedCensus	497,328	15	15,975		30,610	983	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21		** - Please note that the 15 subunits that are being allocated among include a facility in Swansea, IL. This facility was managed from								21
22		7/1/13 thru 3/31/14. The facility units used for the Swansea facility was based on the census through 3/31/14. The Swansea facility								22
23		is not a related party.								23
24										24
25	TOTALS					$ 1,176,515	$ 573,323		$ 76,799	25

Facility Name & ID Number Rosewood Care Ctr of Rckford # 0049270 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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5** Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional Services	WeightedCensus	497,328	15	$ 1,400,742	$	30,610	$ 86,214	1
2	21	Clerical and General Office	WeightedCensus	497,328	15	6,337		30,610	390	2
3	24	Travel and Seminar	WeightedCensus	497,328	15	913		30,610	56	3
4	26	Insurance-Prop./Liab./Malprac.	WeightedCensus	497,328	15	6,835		30,610	421	4
5	32	Interest	WeightedCensus	497,328	15	235,278		30,610	14,481	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								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					$ 1,650,105	$		$ 101,562	25

Facility Name & ID Number Rosewood Care Ctr of Rckford # 0049270 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	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Berkadia		X	Mortgage	$73,916.21	11/1/04	$ 4,941,300	$ 9,875,869	12/1/39	0.0470	$ 233,059	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	14,481	6
7	Bravo Holding Co.)											7
8												8
9	TOTAL Facility Related				$73,916.21		$ 4,941,300	$ 9,875,869			$ 247,540	9
	B. Non-Facility Related*											
10							Less: Interest Income Offset				(26,575)	10
11							Amortization Expense				2,430	11
12							Allocated from Mgmt Co's				472	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (23,673)	14
15	TOTALS (line 9+line14)						$ 4,941,300	$ 9,875,869			$ 223,867	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 25,159 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.)**

Facility Name & ID Number Rosewood Care Ctr of Rckford # 0049270 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 119,535	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	$ 119,733	2
3. Under or (over) accrual (line 2 minus line 1).		$ 198	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 123,537	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.		$ 123,735	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	109,792	8
Taxes Paid-2012	2010	115,223	9
Taxes Paid-2013	2011	119,752	10
Total Taxes Paid	2012	118,352	11
	2013	121,115	12

Accrual based on prior year tax bill.

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. See explanation on Att Sch I

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

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 Rckford COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0049270

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	12-34-102-022	Rosewood Sub	$ 121,114.72	$ 121,114.72
2.		Pt NW 1/4 Sec 34-44-2 Lot 1	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 121,114.72	$ 121,114.72

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.

Facility Name & ID Number Rosewood Care Ctr of Rckford # 0049270 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 41,042 B. General Construction Type: Exterior Stucco Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Rosewood Care Ctr of Rckford # 0049270 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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		2013	1996	$ 2,690,005	$	40	$ 33,625	$ 33,625	$ 33,625	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements - Real Estate Entity										9
10											10
11	None										11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Rosewood Care Ctr of Rckford # 0049270 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Leasehold Improvements - Operating Entity		$	$		$	$	$	37
38									38
39	Painting	2008	21,667	3,096	7	3,096		19,230	39
40	Acrovyn for Doors/Walls/Shelves	2008	5,454	779	7	779		4,415	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									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,717,126	$ 3,875		$ 37,500	$ 33,625	$ 57,270	70

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

Facility Name & ID Number Rosewood Care Ctr of Rckford # 0049270 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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	$ 44,941	$ 8,934	$ 8,934	$	5	$ 10,549	71
72	Current Year Purchases	6,615	944	944		5	944	72
73	Fully Depreciated Assets							73
74	Allocated from Mgmt Co/Real Estate Entity	38,568		8,645	8,645	10	1,928	74
75	TOTALS	$ 90,124	$ 9,878	$ 18,523	$ 8,645		$ 13,421	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)	$ 3,069,724	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 13,753	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 56,023	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 42,270	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 70,691	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 Rckford # 0049270 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: Rockford 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. [X] 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:	1996	120	12/1/07	$ 458,659	5	Unlimited	3
4	Additions							4
5								5
6								6
7	TOTAL		120		$ 458,659 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
   This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A .

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

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	$

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

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO
16. Rental Amount for movable equipment: $ 78,605 Description: Medical Equipment $66,200; Offsite Storage $3472, Home Office Allocation - $8,933
    (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	N/A		$	$	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 Rckford # 0049270 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.)

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

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.

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Rosewood Care Ctr of Rckford # 0049270 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	7,910	$ 320,840	$	7,910	$ 320,840	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		696	37,819		696	37,819	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		7,629	385,257	1,537	7,629	386,794	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				262,821		262,821	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			$	16,235	$ 743,916	$ 264,358	16,235	$ 1,008,274	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 Rckford # 0049270 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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 3,447	$ 33,416	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 304,884)	1,727,292	1,727,292	3
4	Supply Inventory (priced at Cost)	3,459	3,459	4
5	Short-Term Investments			5
6	Prepaid Insurance	11,333	13,808	6
7	Other Prepaid Expenses	3,434	3,434	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): R.E. tax refund & insurance ded			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,748,965	$ 1,781,409	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		262,474	13
14	Buildings, at Historical Cost		2,690,005	14
15	Leasehold Improvements, at Historical Cost	27,121	27,121	15
16	Equipment, at Historical Cost	51,556	90,124	16
17	Accumulated Depreciation (book methods)	(35,138)	(70,691)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		144,470	21
22	Other Long-Term Assets (spe Loan Fees		193,881	22
23	Other(specify): Deposits	2,000	2,000	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 45,539	$ 3,339,384	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,794,504	$ 5,120,793	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 548,123	$ 574,265	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	299,867	299,867	30
31	Accrued Taxes Payable (excluding real estate taxes)	30,514	30,514	31
32	Accrued Real Estate Taxes(Sch.IX-B)		123,537	32
33	Accrued Interest Payable		42,874	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	3,529	3,529	35
	Other Current Liabilities(specify):			
36	Accrued Expenses	136,498	140,498	36
37	Accrued Rent	161,830		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,180,361	$ 1,215,084	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,875,869	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to Bravo Holding Company	3,031,556	3,031,556	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,031,556	$ 12,907,425	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,211,917	$ 14,122,509	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,417,413)	$ (9,001,716)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,794,504	$ 5,120,793	48

***(See instructions.)**

Facility Name & ID Number Rosewood Care Ctr of Rckford # 0049270 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,478,515)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,478,515)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(938,898)	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)**	$ (938,898)	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)**	$ (2,417,413)	24 *

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

Facility Name & ID Number Rosewood Care Ctr of Rckford # 0049270 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,702,699	1
2	Discounts and Allowances for all Levels	(2,004,622)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,698,077	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	304,315	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 304,315	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	3,000	13
14	Non-Patient Meals	4,520	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	32,610	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 40,130	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	26,552	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 26,552	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached Schedule	3,881	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,881	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,072,955	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,059,505	31
32	Health Care	3,696,817	32
33	General Administration	1,167,679	33
	B. Capital Expense		
34	Ownership	1,194,660	34
	C. Ancillary Expense		
35	Special Cost Centers	677,988	35
36	Provider Participation Fee	215,204	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,011,853	40
41	**Income before Income Taxes (line 30 minus line 40)****	(938,898)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (938,898)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,185,185	44
45	Private Pay - Net Inpatient Revenue	1,317,187	45
46	Medicare - Net Inpatient Revenue	2,707,475	46
47	Other-(specify) Insurance	488,230	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,698,077	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 Rckford

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

Schedule 19A

Other Revenue:

Vending Income	**1,751**
Vendor Discount	**1,604**
Miscellaneous	**526**
Total Other Revenue	**3,881**

Facility Name & ID Number Rosewood Care Ctr of Rckford # 0049270 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 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,920	2,036	$ 63,205	$ 31.04	1
2	Assistant Director of Nursing	1,504	1,560	43,027	27.58	2
3	Registered Nurses	31,086	32,954	910,392	27.63	3
4	Licensed Practical Nurses	16,944	17,917	446,047	24.90	4
5	CNAs & Orderlies	67,963	71,482	768,215	10.75	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,977	2,183	25,967	11.90	8
9	Activity Director	2,122	2,275	33,309	14.64	9
10	Activity Assistants	2,982	3,212	27,750	8.64	10
11	Social Service Workers	4,439	4,712	56,577	12.01	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,234	25,675	243,321	9.48	15
16	Dishwashers					16
17	Maintenance Workers	1,238	1,440	14,415	10.01	17
18	Housekeepers	14,494	15,593	146,672	9.41	18
19	Laundry	4,883	5,122	47,019	9.18	19
20	Administrator	2,156	2,376	92,624	38.98	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,601	12,144	109,992	9.06	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,268	4,577	56,722	12.39	31
32	Other Health Care(specify)					32
33	Other(specify) See Sch 20A	10,871	11,650	276,990	23.78	33
34	TOTAL (lines 1 - 33)	204,682	216,908	$ 3,362,244 *	$ 15.50	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 14,558	L1, C3	35
36	Medical Director	Monthly	8,250	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,093	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	2,100	L11, C3	44
45	Social Service Consultant	Monthly	2,100	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 35,101		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	882	$ 37,020	L10, C3	50
51	Licensed Practical Nurses	1,134	37,131	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,016	$ 74,151		53

Rosewood Care Ctr of Rckford

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		2,347	2,538	68,005	26.79
Case Manager		3,988	4,187	118,013	28.19
Ward Clerk		437	604	13,114	21.71
Marketing		4,099	4,321	77,858	18.02
	TOTAL	10,871	11,650	276,990	

Facility Name & ID Number Rosewood Care Ctr of Rckford # 0049270 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Bart Becker	Administrator	0	$ 92,624
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 92,624

B. Administrative - Other

Description	Amount
Mgmt Fees-Bravo Nursing Home Svc-See Page 6, Elimon P 3, C 7	$ 138,000
Mgmt Fees-Midwest Admin Svc-See Page 6, Elimon P 3, C 7 from 1/1/14-6/30/14 (post-acquisition)	105,854
TOTAL (agree to Schedule V, line 17, col. 3)	$ 243,854
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company	Accountant/Consultant	$ 100
Hochschild, Bloom & Company	Accountant/Consultant	3,394
Midwest Administrative Services	Administrative/Bookkeeping	102,350
Claims Administration Services, Inc.	Related Party Legal Fees	5,533
Daniel Maher	Legal Fees	21,516
Healthare Horizons	Healthcare Consultant	1,135
MPRO	Peer Review	855
Mulherin, Rehfeldt & Varchetto	Legal Fees	608
Rockford Register Star	Public Notice	120
Senior Care Capital	Loan Fees	7,500
US Managed Care Services	Managed Care Network	200
Winnebago County Circuit Court	Court Costs	167
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 143,478

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 85,445
Unemployment Compensation Insurance	68,350
FICA Taxes	252,247
Employee Health Insurance	27,345
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	3,417
Employee Uniforms	1,119
Employee Physicals	2,485
Employee Drug Tests	481
Tuition Reimbursement	550
TOTAL (agree to Schedule V, line 22, col.8)	$ 441,439

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	1,335
Health Care Worker Background Check	
(Indicate # of checks performed)	5,820
Patient Background Checks	
Misc. Dues/Subscriptions/Fees	65
Rosewood License Fee	1,500
IHCA Dues	4,232
Misc. Licenses & Fees	2,155
Home Office Allocation	1,541
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,628

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	491
Home Office Allocation	5,622
Seminar Expense	685
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,798

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Rosewood Care Ctr of Rckford # 0049270 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2	N/A												
3													
4													
5													
6													
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14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Rosewood Care Ctr of Rckford # 0049270 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **4,232 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. $ **55,313** 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. $ **215,204**
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. $ **6,271**

(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.