FOR BHF USE

LL1

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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0049791

Facility Name: Rosewood Care Center Of Galesburg

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

County: Knox

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

HFS ID Number: [redacted]

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

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: Steven N. Lavenda **Telephone Number:** ([redacted]
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 07/01/16 to 06/30/17 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)
** Subject to the attached Accountants' Consulting Report*
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

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	180	Skilled (SNF)	180	65,700	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	180	TOTALS	180	65,700	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	18,598	8,949	3,220	30,767	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,598	8,949	3,220	30,767	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 46.83%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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]

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 05/01/2008

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/01/08 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 180 and days of care provided 2,388

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: 06/30/2017 Fiscal Year: 06/30/2017

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

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

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		1,372	382,347	383,719		383,719		383,719			1
2	Food Purchase		330,418		330,418		330,418	(14,475)	315,943			2
3	Housekeeping		13,909	220,918	234,827		234,827		234,827			3
4	Laundry			147,279	147,279		147,279		147,279			4
5	Heat and Other Utilities			165,112	165,112		165,112	(8,460)	156,652			5
6	Maintenance	35,625	2,354	335,937	373,916		373,916	(81,764)	292,152			6
7	Other (specify):*							5,759	5,759			7
8	TOTAL General Services	35,625	348,053	1,251,593	1,635,271		1,635,271	(98,940)	1,536,331			8
	B. Health Care and Programs											
9	Medical Director			22,675	22,675		22,675		22,675			9
10	Nursing and Medical Records	1,956,055	205,395	135,476	2,296,926		2,296,926	35,364	2,332,290			10
10a	Therapy	60,698	688		61,386		61,386		61,386			10a
11	Activities	62,019	4,417	2,200	68,636		68,636		68,636			11
12	Social Services	62,010		2,200	64,210		64,210		64,210			12
13	CNA Training											13
14	Program Transportation			2,199	2,199		2,199		2,199			14
15	Other (specify):*							2,455	2,455			15
16	TOTAL Health Care and Programs	2,140,782	210,500	164,750	2,516,032		2,516,032	37,819	2,553,851			16
	C. General Administration											
17	Administrative	73,358		285,524	358,882		358,882	(254,604)	104,278			17
18	Directors Fees											18
19	Professional Services			83,204	83,204		83,204	9,182	92,386			19
20	Dues, Fees, Subscriptions & Promotions			13,342	13,342		13,342	(957)	12,385			20
21	Clerical & General Office Expenses	106,324	17,237	308,489	432,050		432,050	(108,143)	323,907			21
22	Employee Benefits & Payroll Taxes			356,929	356,929		356,929		356,929			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,863	3,863		3,863	1,009	4,872			24
25	Other Admin. Staff Transportation			7,744	7,744		7,744	9,890	17,634			25
26	Insurance-Prop.Liab.Malpractice			121,200	121,200		121,200	17,371	138,571			26
27	Other (specify):*							22,424	22,424			27
28	TOTAL General Administration	179,682	17,237	1,180,295	1,377,214		1,377,214	(303,828)	1,073,386			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,356,089	575,790	2,596,638	5,528,517		5,528,517	(364,949)	5,163,568			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 Center Of Galesburg #0049791 **Report Period Beginning:** 07/01/16 **Ending:** 06/30/17

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			17,020	17,020		17,020	172,545	189,565			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			401,381	401,381		401,381	1,569,049	1,970,430			32
33	Real Estate Taxes							154,989	154,989			33
34	Rent-Facility & Grounds			902,618	902,618		902,618	(884,233)	18,385			34
35	Rent-Equipment & Vehicles			18,000	18,000		18,000	(18,000)				35
36	Other (specify):*			14,985	14,985		14,985	(14,985)				36
37	**TOTAL Ownership**			1,354,004	1,354,004		1,354,004	979,365	2,333,369			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		105,822	409,229	515,051		515,051		515,051			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			272,310	272,310		272,310		272,310			42
43	Other (specify):*	34,449		2,708	37,157		37,157	(37,157)				43
44	**TOTAL Special Cost Centers**	34,449	105,822	684,247	824,518		824,518	(37,157)	787,361			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,390,538	681,612	4,634,889	7,707,039		7,707,039	577,259	8,284,298			45

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

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

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	(3,588)	02		4
5	Telephone, TV & Radio in Resident Rooms	(8,934)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	5,468	30		9
10	Interest and Other Investment Income	(548)	32		10
11	Discounts, Allowances, Rebates & Refunds	(9,112)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(962)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,372)	21		18
19	Entertainment	(137)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(231,836)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(381,153)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (633,174)		$	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)	1,210,432		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 1,210,432		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 577,258		37

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

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

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

STATE OF ILLINOIS

Rosewood Care Center Of Galesburg

ID# 0049791

Report Period Beginning: 07/01/16

Ending: 06/30/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Salary	$ (33,649)	43	1
2	Marketing Expenses	(2,708)	43	2
3	Bank Charges	(2,613)	21	3
4	Vending Income	(813)	02	4
5	Misc Income	(4,374)	21	5
6	MidCap Line of Credit Fees	(14,985)	36	6
7	Marketing Bonus	(800)	43	7
8	Vendor Late Fees	(18,720)	21	8
9	PAC Dues	(3,899)	20	9
10	Marketing Travel	(491)	25	10
11	Non Allowable Legal	(5,215)	19	11
12	Bldg Co - Audit Fees	(9,720)	19	12
13	Capitalized R&M	(42,991)	06	13
14	Bldg Co - Late Fees	(217,616)	21	14
15	Bldg Co - Line of Credit Fees	(22,559)	36	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**	(381,153)		49

Rosewood Care Center Of Galesburg

ID# 0049791

Report Period Beginning: 07/01/16

Ending: 06/30/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(14,475)											(14,475)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(8,934)					231	242					(8,460)	5
6	Maintenance	(42,991)					100	(38,873)					(81,764)	6
7	Other (specify):*							5,759					5,759	7
8	TOTAL General Services	(66,400)					332	(32,872)					(98,940)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				35,364								35,364	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				2,455								2,455	15
16	TOTAL Health Care and Programs				37,819								37,819	16
	C. General Administration													
17	Administrative				(107,080)		(147,524)						(254,604)	17
18	Directors Fees													18
19	Professional Services	(14,935)	9,720	14,551	352	(506)							9,182	19
20	Fees, Subscriptions & Promotions	(3,899)			4	1	2,819	118					(957)	20
21	Clerical & General Office Expenses	(477,668)	224,816		826	213	142,886	784					(108,143)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			751	116	3	139						1,009	24
25	Other Admin. Staff Transportation	(491)			2,888	20	3,441	4,031					9,890	25
26	Insurance-Prop.Liab.Malpractice		12,153				4,153	1,065					17,371	26
27	Other (specify):*				3,342	25	19,057						22,424	27
28	TOTAL General Administration	(496,993)	246,689	15,302	(99,551)	(243)	24,970	5,998					(303,828)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(563,393)	246,689	15,302	(61,732)	(243)	25,302	(26,874)					(364,949)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 **Report Period Beginning:** 07/01/16 **Ending:** 06/30/17

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	5,468	155,079				11,304	695					172,545	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(548)	1,582,684	(33,574)			20,486						1,569,049	32
33	Real Estate Taxes		154,989										154,989	33
34	Rent-Facility & Grounds		(900,000)				15,767						(884,233)	34
35	Rent-Equipment & Vehicles						(18,000)						(18,000)	35
36	Other (specify):*	(37,544)	22,559										(14,985)	36
37	TOTAL Ownership	(32,624)	1,015,311	(33,574)			29,557	695					979,365	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(37,157)											(37,157)	43
44	TOTAL Special Cost Centers	(37,157)											(37,157)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(633,174)	1,262,000	(18,271)	(61,732)	(243)	54,859	(26,180)					577,259	45

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	34	Rental Income	$ 900,000	Galesburg Real Estate, LLC	100.00%	$	$ (900,000)	1
2	V	19	Audit Fees		Galesburg Real Estate, LLC	100.00%	9,720	9,720	2
3	V	32	Interest Expense - Bank		Galesburg Real Estate, LLC	100.00%	1,140,625	1,140,625	3
4	V	32	Interest Expense - MidCap		Galesburg Real Estate, LLC	100.00%	33,715	33,715	4
5	V	33	Real Estate Tax		Galesburg Real Estate, LLC	100.00%	154,989	154,989	5
6	V	32	Interest Expense - Bhold		Galesburg Real Estate, LLC	100.00%	408,344	408,344	6
7	V	30	Depreciation		Galesburg Real Estate, LLC	100.00%	155,079	155,079	7
8	V	36	MidCap Line of Credit Fees		Galesburg Real Estate, LLC	100.00%	22,559	22,559	8
9	V	21	Base Admin Fee (P. 6D)		Galesburg Real Estate, LLC	100.00%	7,200	7,200	9
10	V	26	Insurance Expense - Property		Galesburg Real Estate, LLC	100.00%	12,153	12,153	10
11	V	21	Vendor Late Charges		Galesburg Real Estate, LLC	100.00%	217,616	217,616	11
12	V								12
13	V								13
14	Total			$ 900,000			$ 2,162,000	$ * 1,262,000	14

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

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

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 FEES	$	BRAVO HOLDING COMPANY	100.00%	$ 14,551	$ 14,551	15
16	V	24	SEMINAR EXPENSE		BRAVO HOLDING COMPANY	100.00%	751	751	16
17	V	32	INTEREST		BRAVO HOLDING COMPANY	100.00%	(33,574)	(33,574)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ (18,271)	$ * (18,271)	39

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

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

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	10	CORPORATE RN SALARIES	$	BRAVO NURSING HOME SERVICES, INC.	100.00%	$ 35,364	$ 35,364	15
16	V	15	CORPORATE RN SALARIES BENEFITS		BRAVO NURSING HOME SERVICES, INC.	100.00%	2,455	2,455	16
17	V	17	ADMINISTRATIVE SALARIES		BRAVO NURSING HOME SERVICES, INC.	100.00%	30,920	30,920	17
18	V	19	PROFESSIONAL FEES		BRAVO NURSING HOME SERVICES, INC.	100.00%	352	352	18
19	V	20	DUES & SUBSCRIPTIONS		BRAVO NURSING HOME SERVICES, INC.	100.00%	4	4	19
20	V	21	OFFICE EXPENSES		BRAVO NURSING HOME SERVICES, INC.	100.00%	826	826	20
21	V	24	SEMINAR & LODGING EXPENSE		BRAVO NURSING HOME SERVICES, INC.	100.00%	116	116	21
22	V	25	AUTO EXPENSE		BRAVO NURSING HOME SERVICES, INC.	100.00%	2,888	2,888	22
23	V	27	ADMINISTRATIVE & OFFICE BENEFITS		BRAVO NURSING HOME SERVICES, INC.	100.00%	3,342	3,342	23
24	V								24
25	V								25
26	V	17	ADMINISTRATIVE FEE	138,000	BRAVO NURSING HOME SERVICES, INC.	100.00%		(138,000)	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			$ 138,000			$ 76,268	$ * (61,732)	39

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

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

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 FEES	$	CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	$ 19	$ 19	15
16	V	20	LICENSES		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	1	1	16
17	V	21	LEGAL SALARIES		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	211	211	17
18	V	21	OFFICE EXPENSE		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	3	3	18
19	V	24	SEMINAR		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	3	3	19
20	V	25	AUTO / TRAVEL EXPENSE		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	20	20	20
21	V	27	EMPLOYEE BENEFITS		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	25	25	21
22	V								22
23	V	19	PROFESSIONAL FEES	525	CLAIMS ADMINISTRATION SERVICES, LLC	100.00%		(525)	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			$ 525			$ 282	$ * (243)	39

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

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

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	$	MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	$ 231	$ 231	15
16	V	6	MAINTENANCE EXPENSE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	100	100	16
17	V	20	DUES, SUBSCRIPTIONS, LICENSES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	2,819	2,819	17
18	V	21	OFFICE SALARIES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	113,496	113,496	18
19	V	21	OFFICE EXPENSES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	36,589	36,589	19
20	V	24	SEMINAR		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	139	139	20
21	V	25	TRAVEL EXPENSE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	3,441	3,441	21
22	V	26	INSURANCE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	4,153	4,153	22
23	V	27	EMPLOYEE BENEFITS		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	19,057	19,057	23
24	V	30	DEPRECIATION		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	11,304	11,304	24
25	V	32	INTEREST		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	20,486	20,486	25
26	V	34	BUILDING RENT		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	15,767	15,767	26
27	V								27
28	V								28
29	V	17	ADMINISTRATIVE FEE	147,524	MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%		(147,524)	29
30	V	21	ADMINISTRATIVE FEE (BLDG CO)	7,200	MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%		(7,200)	30
31	V	35	VEHICLE LEASE	18,000				(18,000)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 172,724			$ 227,583	$ * 54,859	39

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

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

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.	100.00%	$ 242	$ 242	15
16	V	6	MAINTENANCE SALARY		SENIOR LIVING SERVICES, INC.	100.00%	38,345	38,345	16
17	V	6	MAINTENANCE EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	3,437	3,437	17
18	V	7	MAINTENANCE BENEFITS		SENIOR LIVING SERVICES, INC.	100.00%	5,759	5,759	18
19	V	20	LICENSES		SENIOR LIVING SERVICES, INC.	100.00%	118	118	19
20	V	21	OFFICE EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	784	784	20
21	V	25	AUTO / TRAVEL EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	4,031	4,031	21
22	V	26	INSURANCE		SENIOR LIVING SERVICES, INC.	100.00%	1,065	1,065	22
23	V	30	DEPRECIATION		SENIOR LIVING SERVICES, INC.	100.00%	695	695	23
24	V								24
25	V	6	MAINTENANCE SERVICES	80,891	SENIOR LIVING SERVICES, INC.	100.00%	236	(80,655)	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			$ 80,891			$ 54,711	$ * (26,180)	39

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

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

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 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

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 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

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 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

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 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Hinde Feiner	50.00%	Bravo Care of Alton, Inc.	Alton, IL	Galesburg Real Estate, LLC		Lessor	1
2	Hillel Yampol	50.00%	Bravo Care of East Peoria, Inc.	East Peoria, IL	Bravo Administrative Services, Inc.	St. Louis, MO	Administration	2
3			Bravo Care of Edwardsville, Inc.	Edwardsville, IL	Bravo Holding Company, Inc.	St. Louis, MO	Holding Company	3
4			Bravo Care of Elgin, Inc.	Elgin, IL	Bravo Nursing Home Services, Inc.	St. Louis, MO	Management	4
5			Bravo Care of Northbrook, Inc.	Northbrook, IL	Bravo Team Health, Inc.	St. Louis, MO	Human Resources	5
6			Bravo Care of Inverness, Inc.	Inverness, IL	Claims Administration Services, LL	St. Louis, MO	Legal Services	6
7			Bravo Care of Joliet, Inc.	Joliet, IL	Senior Living Services, Inc.	St. Louis, MO	Building Services	7
8			Bravo Care of Moline, Inc.	Moline, IL	Midwest Administrative Services, I	St. Louis, MO	Administration	8
9			Bravo Care of Peoria, Inc.	Peoria, IL	Bravo Care of Wood River, Inc.	Wood River, IL	Supportive Living Facility	9
10			Bravo Care of Rockford, Inc.	Rockford, IL	Rosewood Home Health Services, I	Edwardsville, IL	Home Health	10
11			Bravo Care of St. Charles, Inc.	St. Charles, IL				11
12			Bravo Care of St. Louis, Inc.	St. Louis, MO				12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

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	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$		13

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

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

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

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 [X]

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

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

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

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

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 FEES	PATIENT DAYS	445,412	14	$ 210,656	$	30,767	$ 14,551	1
2	24	SEMINAR EXPENSE	PATIENT DAYS	445,412	14	10,876		30,767	751	2
3	32	INTEREST	PATIENT DAYS	445,412	14	(486,047)		30,767	(33,574)	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ (264,515)	$		$ (18,271)	25

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

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 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	10	CORPORATE RN SALARIES	PAT. DAYS	445,412	14	$ 511,965	$ 511,965	30,767	$ 35,364	1
2	15	CORPORATE RN SALARIES BE	PAT. DAYS	445,412	14	35,539		30,767	2,455	2
3	17	ADMINISTRATIVE SALARIES	PAT. DAYS	445,412	14	447,622	447,622	30,767	30,920	3
4	19	PROFESSIONAL FEES	PAT. DAYS	445,412	14	5,100		30,767	352	4
5	20	DUES & SUBSCRIPTIONS	PAT. DAYS	445,412	14	53		30,767	4	5
6	21	OFFICE EXPENSES	PAT. DAYS	445,412	14	11,963		30,767	826	6
7	24	SEMINAR & LODGING EXPEN	PAT. DAYS	445,412	14	1,683		30,767	116	7
8	25	AUTO EXPENSE	PAT. DAYS	445,412	14	41,816		30,767	2,888	8
9	27	ADMINISTRATIVE & OFFICE I	PAT. DAYS	445,412	14	48,387		30,767	3,342	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,104,130	$ 959,587		$ 76,268	25

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

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 FEES	ACTUAL FEES	439,804	14	$ 15,685	$	525	$ 19	1
2	20	LICENSES	ACTUAL FEES	439,804	14	1,155		525	1	2
3	21	LEGAL SALARIES	ACTUAL FEES	439,804	14	176,396	176,396	525	211	3
4	21	OFFICE EXPENSE	ACTUAL FEES	439,804	14	2,382		525	3	4
5	24	SEMINAR	ACTUAL FEES	439,804	14	2,470		525	3	5
6	25	AUTO / TRAVEL EXPENSE	ACTUAL FEES	439,804	14	17,094		525	20	6
7	27	EMPLOYEE BENEFITS	ACTUAL FEES	439,804	14	20,803		525	25	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 235,985	$ 176,396		$ 282	25

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

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, IN
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	PAT. DAYS	445,412	14	$ 3,350	$	30,767	$ 231	1
2	6	MAINTENANCE EXPENSE	PAT. DAYS	445,412	14	1,452		30,767	100	2
3	20	DUES, SUBSCRIPTIONS, LICEN	PAT. DAYS	445,412	14	40,807		30,767	2,819	3
4	21	OFFICE SALARIES	PAT. DAYS	445,412	14	1,643,080	1,643,080	30,767	113,496	4
5	21	OFFICE EXPENSES	PAT. DAYS	445,412	14	529,702		30,767	36,589	5
6	24	SEMINAR	PAT. DAYS	445,412	14	2,006		30,767	139	6
7	25	TRAVEL EXPENSE	PAT. DAYS	445,412	14	49,808		30,767	3,441	7
8	26	INSURANCE	PAT. DAYS	445,412	14	60,126		30,767	4,153	8
9	27	EMPLOYEE BENEFITS	PAT. DAYS	445,412	14	275,890		30,767	19,057	9
10	30	DEPRECIATION	PAT. DAYS	445,412	14	163,642		30,767	11,304	10
11	32	INTEREST	PAT. DAYS	445,412	14	296,581		30,767	20,486	11
12	34	BUILDING RENT	PAT. DAYS	445,412	14	228,258		30,767	15,767	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,294,702	$ 1,643,080		$ 227,583	25

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

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	ACTUAL FEES	931,614	14	$ 2,789	$	80,891	$ 242	1
2	6	MAINTENANCE SALARY	ACTUAL FEES	931,614	14	441,618	441,618	80,891	38,345	2
3	6	MAINTENANCE EXPENSE	ACTUAL FEES	931,614	14	39,580		80,891	3,437	3
4	7	MAINTENANCE BENEFITS	ACTUAL FEES	931,614	14	66,326		80,891	5,759	4
5	20	LICENSES	ACTUAL FEES	931,614	14	1,361		80,891	118	5
6	21	OFFICE EXPENSE	ACTUAL FEES	931,614	14	9,024		80,891	784	6
7	25	AUTO / TRAVEL EXPENSE	ACTUAL FEES	931,614	14	46,424		80,891	4,031	7
8	26	INSURANCE	ACTUAL FEES	931,614	14	12,265		80,891	1,065	8
9	30	DEPRECIATION	ACTUAL FEES	931,614	14	8,001		80,891	695	9
10										10
11	6	MAINTENANCE SERVICES	DIRECT ALLOCATION		14	4,421			236	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 631,809	$ 441,618		$ 54,711	25

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	MidCap		X	Mortgage	25,000 + Int		$ 12,000,000	$ 7,500,000			$ 1,140,625	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MidCap		X	Line of Credit				6,553,236			401,381	6
7	MidCap (Bldg Co)		X	Note Payable				8,205,745			442,059	7
8												8
9	TOTAL Facility Related						$ 12,000,000	$ 22,258,981			$ 1,984,065	9
	B. Non-Facility Related*											
10	Interest Income		X								(548)	10
11	Alloc Midwest Admin Svcs										20,486	11
12	Alloc Bravo Holding Co										(33,574)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (13,636)	14
15	TOTALS (line 9+line14)						$ 12,000,000	$ 22,258,981			$ 1,970,429	15

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

* 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 Center Of Galesburg **#** 0049791 **Report Period Beginning:** 07/01/16 **Ending:** 06/30/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 150,210	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.)		$ 155,977	2
3. Under or (over) accrual (line 2 minus line 1).		$ 5,767	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 149,222	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.		$ 154,989	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2012	139,437	8
2013	145,055	9
2014	148,301	10
2015	152,281	11
2016	159,672	12

Accrual based on prior year tax bill.

Amount on line 2 includes the second installment of the 2015 tax bill and the first installment of the 2016 tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rosewood Care Center Of Galesburg COUNTY Knox

FACILITY IDPH LICENSE NUMBER 0049791

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	99-04-251-012	Rosewood Sub Lots 2 & 3	$ 159,671.70	$ 159,671.70
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 159,671.70	$ 159,671.70

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 REAL ESTATE TAX COST DOCUMENTATION

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

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

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rosewood Care Center Of Galesburg COUNTY Knox

FACILITY IDPH LICENSE NUMBER 0049791

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [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: 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	5 acres	1987	$ 182,779	1
2					2
3	TOTALS			$ 182,779	3

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

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		1987	1987	$ 2,297,757	$ 155,079	25-40	$ 68,790	$ (86,289)	$ 1,957,237	4
5	60		1998	1998	2,243,326		25-40	72,617	72,617	1,437,038	5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

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			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		452,409			12,415	12,415	281,854	67
68	Related Party Allocations (Pages 12H & 12I)		340	68		68		68	68
69	Financial Statement Depreciation			17,020			(17,020)		69
70	TOTAL (lines 4 thru 69)		$ 4,993,832	$ 172,167		$ 153,890	$ (18,277)	$ 3,676,197	70

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

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,993,832	$ 172,167		$ 153,890	$ (18,277)	$ 3,676,197	1
2	Install Check Valves/Return Line/Holbi Valve/ And Heater Piping	2015	3,981		20	199	199	398	2
3	Electrical; Fire System Tripped	2016	3,884		20	194	194	388	3
4	Ground Fault Isolation/Replacement In Lobby/Nurses Station/600	2016	2,810		20	141	141	282	4
5	Replacement Fire Alarm Control Panel & Annunciators	2016	2,978		20	149	149	298	5
6	Installed, Prgrammed, Inspected Fire Alarm Control - Main Syste	2016	3,200		20	160	160	160	6
7	Replaced Ps-40 In 600-800 Wing, Ps-10 In 100-400 Wing	2016	2,871		20	144	144	144	7
8	Inspected And Repaired Dry System - Main Fire System	2017	9,386		20	469	469	469	8
9	Repaired Leaking Heat Exchanger On Main Boiler Unit	2017	23,869		20	1,193	1,193	1,193	9
10	Removed Old Expansion Tank And Installed New One	2017	3,665		20	183	183	183	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,050,476	$ 172,167		$ 156,722	$ (15,445)	$ 3,679,712	34

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

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,050,476	$ 172,167		$ 156,722	$ (15,445)	$ 3,679,712	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,050,476	$ 172,167		$ 156,722	$ (15,445)	$ 3,679,712	34

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

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 5,050,476	$ 172,167		$ 156,722	$ (15,445)	$ 3,679,712	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,050,476	$ 172,167		$ 156,722	$ (15,445)	$ 3,679,712	34

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

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 5,050,476	$ 172,167		$ 156,722	$ (15,445)	$ 3,679,712	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,050,476	$ 172,167		$ 156,722	$ (15,445)	$ 3,679,712	34

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

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Facility Signage	1887	3,423		10			3,423	9
10	Exhaust Hood & Fire Suppression System	1987	9,019		10			9,019	10
11	Nurse Call System & Paging System	1987	45,340		10			45,340	11
12	Seeding / Landscaping / Berm	1988	31,414		25			31,414	12
13	18 Bed Addition	1989	49,460		40	1,237	1,237	34,427	13
14	Painting	1991	1,360		10			1,360	14
15	Facility Signage	1991	3,733		10			3,733	15
16	Painting	1992	1,520		10			1,520	16
17	Roof Vents	1992	6,896		40	172	172	4,352	17
18	Parking Lot Improvements	1992	5,673		25	227	227	5,654	18
19	Water Heaters	1992	3,123		10			3,123	19
20	Irrigation System	1994	7,253		25	290	290	6,963	20
21	Landscaping	1998	3,183		25	127	127	2,418	21
22	Shingle Roof Replacement	2002	102,091		40	2,552	2,552	39,772	22
23	Seal & Restripe Parking Lot	2003	14,545		25	582	582	8,097	23
24	Repair Soffit & Facia on Gables	2003	5,394		40	135	135	1,844	24
25	Air Conditioning Unit & Heat Pumps	2003	9,817		10			9,817	25
26	Boiler	2003	20,269		10			20,269	26
27	Heat Pumps	2004	2,875		10			2,875	27
28	Paint Exterior of Building	2005	2,875		40	72	72	893	28
29	Fire Alarm Panel	2005	2,647		10	44	44	2,647	29
30	Console Heat Pumps	2006	6,337		10	422	422	6,337	30
31	Seal & Stripe Parking Lot	2006	5,195		25	208	208	2,200	31
32	Replace Sidewalk	2007	5,778		40	144	144	1,395	32
33	Seal & Stripe Parking Lot	2008	6,245		25	250	250	2,249	33
34	TOTAL (lines 1 thru 33)		$ 355,465	$		$ 6,462	$ 6,462	$ 251,141	34

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

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 355,465	$		$ 6,462	$	$ 251,141	1
2	Shower Improvements	2008	10,336		40	258	258	2,303	2
3	Heat Pumps	2009	4,218		10	422	422	3,234	3
4	Seal & Stripe Parking Lot	2010	6,975		25	279	279	1,953	4
5	Generator	2010	4,888		10	489	489	3,218	5
6	Doors	2011	14,790		10	1,479	1,479	8,504	6
7	Sprinkler	2012	6,753		10	675	675	3,657	7
8	Sprinkler	2012	3,704		40	93	93	456	8
9	Boiler / Burner / Pump	2013	8,358		40	209	209	836	9
10	New Window Sills & Counters	2013	3,710		40	93	93	372	10
11	Firestopping Corridor Controls	2013	5,012		40	125	125	479	11
12	HVAC Improvements	2014	8,156		10	816	816	2,856	12
13	Seal Coating & Alphalt Repair - Front & Back Lot & Drive	2014	12,885		25	515	515	1,417	13
14	Replace Hot Water Heater in Laundry	2014	4,279		10	428	428	1,284	14
15	Fire Alarm Control Panel	2016	2,880		10	72	72	144	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 452,409	$		$ 12,415	$ 5,953	$ 281,854	34

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

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Senior Living Services	2017	340	68	5	68		68	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 340	$ 68		$ 68	$	$ 68	34

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

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 340	$ 68		$ 68	$	$ 68	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 340	$ 68		$ 68	$	$ 68	34

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

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

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	$ 949,747	$ 2,543	$ 23,456	$ 20,913	10	$ 912,819	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	17,128	90	90		10	17,128	73
74								74
75	TOTALS	$ 966,875	$ 2,633	$ 23,546	$ 20,913		$ 929,947	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Midwest Adminis	1900	$ 46,353	$ 8,670	$ 8,670	$	5	$ 38,155	76
77		Allocated from Senior Living Ser	1900	12,996	627	627		5	12,788	77
78										78
79										79
80	TOTALS			$ 59,349	$ 9,297	$ 9,297	$		$ 50,943	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,259,479	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 184,097	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 189,565	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 5,468	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,660,602	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Off Site Storage				2,618			5
6	Allocated from Midwest Admin Services				15,767			6
7	TOTAL				$ 18,385 **			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.	/2018	$
13.	/2019	$
14.	/2020	$

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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

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

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

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	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 Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

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

   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 Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 174,437	$		$ 174,437	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			14,627			14,627	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			211,515			211,515	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				92,145		92,145	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					8,650	13,677		22,327	13
14	TOTAL			$		$ 409,229	$ 105,822		$ 515,051	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.

STATE OF ILLINOIS

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/17 (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	$ 1,295	$ 1,295	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,152,036	2,152,036	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	72,970	77,196	6
7	Other Prepaid Expenses	4,447	4,447	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	2,000	2,000	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,232,748	$ 2,236,974	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		182,779	13
14	Buildings, at Historical Cost		4,806,863	14
15	Leasehold Improvements, at Historical Cost		695,461	15
16	Equipment, at Historical Cost	85,099	1,092,101	16
17	Accumulated Depreciation (book methods)	(74,476)	(4,578,619)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 10,623	$ 2,198,585	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,243,371	$ 4,435,559	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,974,308	$ 2,011,744	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	6,553,236	6,553,236	29
30	Accrued Salaries Payable	134,565	134,565	30
31	Accrued Taxes Payable (excluding real estate taxes)	164,009	164,009	31
32	Accrued Real Estate Taxes(Sch.IX-B)		149,222	32
33	Accrued Interest Payable		1,672,359	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	14,235	35,105	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	2,777,549	592,120	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 11,617,902	$ 11,312,360	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		15,705,745	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)**	$	$ 15,705,745	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 11,617,902	$ 27,018,105	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (9,374,531)	$ (22,582,546)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,243,371	$ 4,435,559	48

*(See instructions.)

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 **Report Period Beginning:** 07/01/16 **Ending:** 06/30/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (7,437,770)	1
2	Restatements (describe):		2
3	Late 2016 Journal Entry	(396)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (7,438,166)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,936,365)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,936,365)	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)**	$ (9,374,531)	24 *

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

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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	$ 5,545,203	1
2	Discounts and Allowances for all Levels	(1,065,288)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,479,915	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,122,061	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,122,061	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	1,800	13
14	Non-Patient Meals	3,588	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	105,790	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,876	19
20	Radiology and X-Ray	2,008	20
21	Other Medical Services	29,789	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 153,851	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	548	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 548	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	14,299	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 14,299	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,770,674	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,635,271	31
32	Health Care	2,516,032	32
33	General Administration	1,377,214	33
	B. Capital Expense		
34	Ownership	1,354,004	34
	C. Ancillary Expense		
35	Special Cost Centers	552,208	35
36	Provider Participation Fee	272,310	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,707,039	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,936,365)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,936,365)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,328,233	44
45	Private Pay - Net Inpatient Revenue	1,646,204	45
46	Medicare - Net Inpatient Revenue	398,748	46
47	Other-(specify) Insurance/Managed Care	106,730	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,479,915	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.**

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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	2,148	2,310	$ 69,801	$ 30.22	1
2	Assistant Director of Nursing	2,099	2,257	47,734	21.15	2
3	Registered Nurses	14,850	15,013	386,119	25.72	3
4	Licensed Practical Nurses	23,399	25,508	488,730	19.16	4
5	CNAs & Orderlies	81,814	87,244	911,755	10.45	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,357	3,568	60,698	17.01	8
9	Activity Director	3,124	3,359	30,866	9.19	9
10	Activity Assistants	2,511	2,735	31,153	11.39	10
11	Social Service Workers	4,313	4,638	62,010	13.37	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	2,426	2,608	35,625	13.66	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,643	1,766	73,358	41.54	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,552	9,221	106,324	11.53	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	4,374	4,422	51,916	11.74	31
32	Other Health Care(specify)					32
33	Other(specify)	1,925	2,070	34,449	16.64	33
34	TOTAL (lines 1 - 33)	156,535	166,719	$ 2,390,538 *	$ 14.34	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		$		35
36	Medical Director	Monthly	22,675	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,927	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,200	11-03	44
45	Social Service Consultant	Monthly	2,200	12-03	45
46	Other(specify)				46
47	Outsourced Dietary	Monthly	382,347	01-03	47
48					48
49	TOTAL (lines 35 - 48)		$ 417,349		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	241	$ 9,653	10-03	50
51	Licensed Practical Nurses	2,915	116,617	10-03	51
52	Certified Nurse Assistants/Aides	32	1,279	10-03	52
53	TOTAL (lines 50 - 52)	3,189	$ 127,549		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Chad Coultier	Administrator	0	$ 73,358
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 73,358

B. Administrative - Other

Description	Amount
Mgmt Fees - Bravo Nursing Home	$ 138,000
Mgmt Fees - MidWest Admin Services	147,524
TOTAL (agree to Schedule V, line 17, col. 3)	$ 285,524
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	$ 8,745
Ability Network Inc	Software	6,476
Quality Healthcare Resources	Financial Services	20,300
Resolute Healthcare Solutions	Audit	5,019
Claims Administration Services, Inc	Related Party Legal	525
Infinite Solutions	IT Consultants	31,939
Marcum, LLP	Accounting	10,200
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 83,204

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 71,496
Unemployment Compensation Insurance	19,154
FICA Taxes	177,632
Employee Health Insurance	63,790
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Insurance Expense	9,142
Dental Insurance	2,588
Employee Relations	2,498
401K Expense	8,248
Employee Physicals	2,381
TOTAL (agree to Schedule V, line 22, col.8)	$ 356,929

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	1,108
Health Care Worker Background Check	
(Indicate # of checks performed 190)	1,896
Patient Background Checks	
Dues & Subscriptions	2,459
Allocated from Bravo Nursing Home Svcs	4
Allocated from Claims Admin Services	1
See Supplemental Schedule	2,937
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,385

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,863
Allocated from Bravo Holding	751
Alocated from Bravo Nursing	116
See Supplemental Schedule	142
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,872

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Rosewood Care Center Of Galesburg # 0049791 Report Period Beginning: 07/01/16 Ending: 06/30/17

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA: $9870**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **48,174** 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. $ **272,310**
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. $ Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **3,588**

(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