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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0049304

Facility Name: Rosewood Care Ctr of Moline

Address: 7300 34th Avenue (Number) Moline (City) 61265 (Zip Code)

County: Rock Island

Telephone Number: (309)792-5942 **Fax #** (309)792-5975

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Larry Templin **Telephone Number:** (630) 361-2868
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2014 to 06/30/2015 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) Jack McKittrick
(Title) Chief Financial Officer

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, P.O. Box 9, Dunlap, IL 61525
(Telephone) (630) 361-2868 Fax # ( )

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Moline # 0049304 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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 _____

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	16,852	11,370	7,153	35,375	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,852	11,370	7,153	35,375	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.76%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 58 and days of care provided 4,938

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: 6/30/2015 Fiscal Year: 6/30/2015

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Moline # 0049304 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger: Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	249,072	24,541	9,280	282,893		282,893	4,702	287,595			1
2	Food Purchase		225,885		225,885		225,885	(11,870)	214,015			2
3	Housekeeping	18,717	12,121	138,760	169,598		169,598		169,598			3
4	Laundry	4,829	10,025	92,507	107,361		107,361		107,361			4
5	Heat and Other Utilities			134,069	134,069		134,069	472	134,541			5
6	Maintenance	31,790	4,803	154,838	191,431		191,431	(8,835)	182,596			6
7	Other (specify):* Allocated HO Benefits							5,023	5,023			7
8	**TOTAL General Services**	304,408	277,375	529,454	1,111,237		1,111,237	(10,508)	1,100,729			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,728,059	182,056	28,060	1,938,175		1,938,175	52,869	1,991,044			10
10a	Therapy		1,090	676,617	677,707		677,707		677,707			10a
11	Activities	51,826	4,146	1,800	57,772		57,772		57,772			11
12	Social Services	40,355		1,800	42,155		42,155		42,155			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Allocated HO Benefits							5,608	5,608			15
16	**TOTAL Health Care and Programs**	1,820,240	187,292	726,277	2,733,809		2,733,809	58,477	2,792,286			16
	C. General Administration											
17	Administrative	89,539		352,685	442,224		442,224	(291,734)	150,490			17
18	Directors Fees											18
19	Professional Services			96,811	96,811		96,811	178,966	275,777			19
20	Dues, Fees, Subscriptions & Promotions			11,780	11,780		11,780	6,402	18,182			20
21	Clerical & General Office Expenses	77,011	18,643	149,323	244,977		244,977	184,654	429,631			21
22	Employee Benefits & Payroll Taxes			387,479	387,479		387,479		387,479			22
23	Inservice Training & Education											23
24	Travel and Seminar			206	206		206	10,625	10,831			24
25	Other Admin. Staff Transportation			4,955	4,955		4,955	3,834	8,789			25
26	Insurance-Prop.Liab.Malpractice			15,281	15,281		15,281	14,149	29,430			26
27	Other (specify):* Allocated HO Benefits							27,058	27,058			27
28	**TOTAL General Administration**	166,550	18,643	1,018,520	1,203,713		1,203,713	133,954	1,337,667			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,291,198	483,310	2,274,251	5,048,759		5,048,759	181,923	5,230,682			29

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

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

Facility Name & ID Number Rosewood Care Ctr of Moline #0049304 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			11,831	11,831		11,831	142,216	154,047			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			144,803	144,803		144,803	248,170	392,973			32
33	Real Estate Taxes							124,378	124,378			33
34	Rent-Facility & Grounds			1,177,648	1,177,648		1,177,648	(1,164,923)	12,725			34
35	Rent-Equipment & Vehicles			25,619	25,619		25,619	2,257	27,876			35
36	Other (specify):* Mortgage Ins.							28,206	28,206			36
37	TOTAL Ownership			1,359,901	1,359,901		1,359,901	(619,696)	740,205			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		233,236		233,236		233,236		233,236			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			243,842	243,842		243,842		243,842			42
43	Other (specify):* See Att Sch 4A	83,685		111,836	195,521		195,521	(168,793)	26,728			43
44	TOTAL Special Cost Centers	83,685	233,236	355,678	672,599		672,599	(168,793)	503,806			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,374,883	716,546	3,989,830	7,081,259		7,081,259	(606,566)	6,474,693			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Care Ctr of Moline

Period Beginning 07/01/2014
Period End 06/30/2015

Schedule 4A

V. Cost Center Expenses

		Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
		1	2	3	4	5	6	7	8	9	10	
	Ancillary Expense											
	E. Special Cost Centers											
43	Other (specify):*				0		0		0			
	Laboratory/Cons bill Expenses			20,307	20,307		20,307		20,307			
	Radiology Expenses			6,421	6,421		6,421		6,421			
	Non-Allowable Expenses	83,685		85,108	168,793		168,793	(168,793)	0			
					0		0		0			
					0		0		0			
	TOTAL Other Special Cost Centers	83,685	0	111,836	195,521	0	195,521	(168,793)	26,728			

Facility Name & ID Number Rosewood Care Ctr of Moline # 0049304 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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	(7,973)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,265)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(2,971)	32		10
11	Discounts, Allowances, Rebates & Refunds	(3,898)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(448)	43		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,031)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(74,210)	43		24
25	Fund Raising, Advertising and Promotional	(2,853)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(332)	43		28
29	Other-Attach Schedule See Page 5A	(96,630)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (202,611)		$	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)	(403,955)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (403,955)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (606,566)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Care Ctr of Moline

ID# 0049304

Report Period Beginning: 07/01/2014

Ending: 06/30/2015

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate Marketing Salary	$ (83,685)	43	1
2	Eliminate Lobbying & PAC Dues	(1,318)	20	2
3	Miscellaneous Income Offset	(299)	21	3
4	Management Fee-Real Estate Entity	(7,200)	17	4
5	Mileage Reimbursement Related to Marketing	(4,128)	25	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(96,630)		49

Facility Name & ID Number Rosewood Care Ctr of Moline # 0049304 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Bravo Nursing Home Services, Inc.	0.00%	$ 845	$ 845	1
2	V	6	Maintenance		Bravo Nursing Home Services, Inc.	0.00%	30	30	2
3	V	7	Mgmt. Allocation of Benefits		Bravo Nursing Home Services, Inc.	0.00%	90	90	3
4	V	10	Nursing & Medical Records		Bravo Nursing Home Services, Inc.	0.00%	42,275	42,275	4
5	V	15	Mgmt. Allocation of Benefits		Bravo Nursing Home Services, Inc.	0.00%	4,490	4,490	5
6	V	17	Administrative	138,000	Bravo Nursing Home Services, Inc.	0.00%	15,364	(122,636)	6
7	V	19	Professional Services		Bravo Nursing Home Services, Inc.	0.00%	119	119	7
8	V	20	Dues, Fees, Subs & Promotions		Bravo Nursing Home Services, Inc.	0.00%	59	59	8
9	V	21	Clerical and General Office		Bravo Nursing Home Services, Inc.	0.00%	51,078	51,078	9
10	V	24	Travel and Seminar		Bravo Nursing Home Services, Inc.	0.00%	2,290	2,290	10
11	V	25	Other Admin. Staff Transport.		Bravo Nursing Home Services, Inc.	0.00%	2,023	2,023	11
12	V	26	Insurance-Prop./Liab./Malprac.		Bravo Nursing Home Services, Inc.	0.00%	221	221	12
13	V	27	Mgmt. Allocation of Benefits		Bravo Nursing Home Services, Inc.	0.00%	6,922	6,922	13
14	Total			$ 138,000			$ 125,806	$ * (12,194)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Moline # 0049304 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Midwest Administrative Services, Inc.	0.00%	$ 3,857	$ 3,857	15
16	V	2	Food		Midwest Administrative Services, Inc.	0.00%	1	1	16
17	V	5	Utilities		Midwest Administrative Services, Inc.	0.00%	153	153	17
18	V	6	Maintenance		Midwest Administrative Services, Inc.	0.00%	1,170	1,170	18
19	V	7	Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	407	407	19
20	V	10	Nursing and Medical Records		Midwest Administrative Services, Inc.	0.00%	10,594	10,594	20
21	V	15	Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	1,118	1,118	21
22	V	17	Administrative	214,685	Midwest Administrative Services, Inc.	0.00%	45,587	(169,098)	22
23	V	19	Professional Services		Midwest Administrative Services, Inc.	0.00%	8,110	8,110	23
24	V	20	Dues, Fees, Subs & Promotions		Midwest Administrative Services, Inc.	0.00%	7,593	7,593	24
25	V	21	Clerical and General Office	61,107	Midwest Administrative Services, Inc.	0.00%	167,983	106,876	25
26	V	24	Travel and Seminar		Midwest Administrative Services, Inc.	0.00%	3,548	3,548	26
27	V	25	Other Admin. Staff Transport.		Midwest Administrative Services, Inc.	0.00%	2,019	2,019	27
28	V	26	Insurance-Prop./Liab./Malprac.		Midwest Administrative Services, Inc.	0.00%	4,082	4,082	28
29	V	27	Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	18,279	18,279	29
30	V	30	Depreciation		Midwest Administrative Services, Inc.	0.00%	17,131	17,131	30
31	V	32	Interest		Midwest Administrative Services, Inc.	0.00%	13,655	13,655	31
32	V	34	Rent-Facility and Grounds		Midwest Administrative Services, Inc.	0.00%	12,725	12,725	32
33	V	35	Rent-Equipment & Vehicles		Midwest Administrative Services, Inc.	0.00%	2,257	2,257	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 275,792			$ 320,269	$ * 44,477	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Moline # 0049304 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Services	$ 8,687	Claims Administration Services, LLC	0.00%	$ 299	$ (8,388)	15
16	V	21	Clerical and General Office		Claims Administration Services, LLC	0.00%	17,277	17,277	16
17	V	24	Travel and Seminar		Claims Administration Services, LLC	0.00%	996	996	17
18	V	25	Other Admin. Staff Transport.		Claims Administration Services, LLC	0.00%	522	522	18
19	V	26	Insurance-Prop./Liab./Malprac.		Claims Administration Services, LLC	0.00%	221	221	19
20	V	27	Mgmt. Allocation of Benefits		Claims Administration Services, LLC	0.00%	1,857	1,857	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			$ 8,687			$ 21,172	$ * 12,485	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Moline # 0049304 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	Senior Living Services, Inc.	0.00%	$ 319	$ 319	15
16	V	6	Maintenance	47,788	Senior Living Services, Inc.	0.00%	37,753	(10,035)	16
17	V	7	Mgmt. Allocation of Benefits		Senior Living Services, Inc.	0.00%	4,526	4,526	17
18	V	19	Professional Services		Senior Living Services, Inc.	0.00%	9	9	18
19	V	21	Clerical and General Office		Senior Living Services, Inc.	0.00%	779	779	19
20	V	24	Travel and Seminar		Senior Living Services, Inc.	0.00%	3,491	3,491	20
21	V	25	Other Admin. Staff Transport.		Senior Living Services, Inc.	0.00%	3,090	3,090	21
22	V	26	Insurance-Prop./Liab./Malprac.		Senior Living Services, Inc.	0.00%	911	911	22
23	V	30	Depreciation		Senior Living Services, Inc.	0.00%	1,254	1,254	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			$ 47,788			$ 52,132	$ * 4,344	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Moline # 0049304 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Services	$	Bravo Holding Company	0.00%	$ 179,057	$ 179,057	15
16	V	20	Fees & Subscriptions		Bravo Holding Company	0.00%	68	68	16
17	V	21	Clerical and General Office		Bravo Holding Company	0.00%	915	915	17
18	V	24	Travel and Seminar		Bravo Holding Company	0.00%	300	300	18
19	V	25	Other Admin. Staff Transport.		Bravo Holding Company	0.00%	308	308	19
20	V	26	Insurance-Prop./Liab./Malprac.		Bravo Holding Company	0.00%	731	731	20
21	V	32	Interest	73,766	Bravo Holding Company	0.00%	19,249	(54,517)	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			$ 73,766			$ 200,628	$ * 126,862	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Moline # 0049304 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Administrative	$	Moline Real Estate, Inc.	0.00%	$ 7,200	$ 7,200	15
16	V	19	Professional Services		Moline Real Estate, Inc.	0.00%	6,090	6,090	16
17	V	21	Clerical and General Office		Moline Real Estate, Inc.	0.00%	8,028	8,028	17
18	V	26	Insurance-Prop./Liab./Malprac.		Moline Real Estate, Inc.	0.00%	7,983	7,983	18
19	V	30	Depreciation		Moline Real Estate, Inc.	0.00%	123,831	123,831	19
20	V	32	Interest	31	Moline Real Estate, Inc.	0.00%	292,034	292,003	20
21	V	33	Real Estate Taxes		Moline Real Estate, Inc.	0.00%	124,378	124,378	21
22	V	34	Rent-Facility and Grounds	1,177,648	Moline Real Estate, Inc.	0.00%		(1,177,648)	22
23	V	36	Mortgage Insurance		Moline Real Estate, Inc.	0.00%	28,206	28,206	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,177,679			$ 597,750	$ * (579,929)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Moline # 0049304 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

VII. RELATED PARTIES

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Moline # 0049304 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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	Mark Yampol	CEO	Administrative	0.00	56,402	4.97	9.94	Salary	4,588	L17, C7	1
2	Mark Yampol	CEO	Administrative	0.00	1,387,170	See Above	See Above	Consulting	112,830	L19, C7	2
3	Hillel Yampol	Owner	Administrative	0.00	44,517	4.97	9.94	Salary	3,621	L17, C7	3
4	Christene Rene Yampol	Owner	Administrative	0.00	66,593	4.97	9.94	Salary	5,417	L17, C7	4
5											5
6	See Attached Schedule 7A										6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 126,456		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Moline # 0049304 Report Period Beginning: 07/01/2014 Ending: 6/30/2015

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	WeightedCensus	470,290	14	11,239	11,239	35,375	$ 845	1
2	6	Maintenance	WeightedCensus	470,290	14	397		35,375	30	2
3	7	Mgmt. Allocation of Benefits	WeightedCensus	470,290	14	1,193		35,375	90	3
4	10	Nursing & Medical Records	WeightedCensus	470,290	14	562,016	562,016	35,375	42,275	4
5	15	Mgmt. Allocation of Benefits	WeightedCensus	470,290	14	59,699		35,375	4,490	5
6	17	Administrative	WeightedCensus	470,290	14	204,253	204,253	35,375	15,364	6
7	19	Professional Services	WeightedCensus	470,290	14	1,579		35,375	119	7
8	20	Dues, Fees, Subs & Promotions	WeightedCensus	470,290	14	786		35,375	59	8
9	21	Clerical and General Office	WeightedCensus	470,290	14	679,056	662,076	35,375	51,078	9
10	24	Travel and Seminar	WeightedCensus	470,290	14	30,438		35,375	2,290	10
11	25	Other Admin. Staff Transport.	WeightedCensus	470,290	14	26,889		35,375	2,023	11
12	26	Insurance-Prop./Liab./Malprac.	WeightedCensus	470,290	14	2,943		35,375	221	12
13	27	Mgmt. Allocation of Benefits	WeightedCensus	470,290	14	92,023		35,375	6,922	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					$ 1,672,511	$ 1,439,584		$ 125,806	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Moline # 0049304 Report Period Beginning: 07/01/2014 Ending: 6/30/2015

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	WeightedCensus	470,290	14	51,283	51,283	35,375	$ 3,857	1
2	2	Food	WeightedCensus	470,290	14	13		35,375	1	2
3	5	Utilities	WeightedCensus	470,290	14	2,032		35,375	153	3
4	6	Maintenance	WeightedCensus	470,290	14	15,554		35,375	1,170	4
5	7	Mgmt. Allocation of Benefits	WeightedCensus	470,290	14	5,409		35,375	407	5
6	10	Nursing and Medical Records	WeightedCensus	470,290	14	140,839	140,839	35,375	10,594	6
7	15	Mgmt. Allocation of Benefits	WeightedCensus	470,290	14	14,860		35,375	1,118	7
8	17	Administrative	WeightedCensus	470,290	14	606,045	606,045	35,375	45,587	8
9	19	Professional Services	WeightedCensus	470,290	14	107,816		35,375	8,110	9
10	20	Dues, Fees, Subs & Promotions	WeightedCensus	470,290	14	100,942		35,375	7,593	10
11	21	Clerical and General Office	WeightedCensus	470,290	14	2,233,257	1,697,067	35,375	167,983	11
12	24	Travel and Seminar	WeightedCensus	470,290	14	47,164		35,375	3,548	12
13	25	Other Admin. Staff Transport.	WeightedCensus	470,290	14	26,845		35,375	2,019	13
14	26	Insurance-Prop./Liab./Malprac.	WeightedCensus	470,290	14	54,274		35,375	4,082	14
15	27	Mgmt. Allocation of Benefits	WeightedCensus	470,290	14	243,011		35,375	18,279	15
16	30	Depreciation	WeightedCensus	470,290	14	227,745		35,375	17,131	16
17	32	Interest	WeightedCensus	470,290	14	181,530		35,375	13,655	17
18	34	Rent-Facility and Grounds	WeightedCensus	470,290	14	169,173		35,375	12,725	18
19	35	Rent-Equipment & Vehicles	WeightedCensus	470,290	14	30,003		35,375	2,257	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,257,795	$ 2,495,234		$ 320,269	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Moline # 0049304 Report Period Beginning: 07/01/2014 Ending: 6/30/2015

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional Services	WeightedCensus	470,290	14	3,980		35,375	$ 299	1
2	21	Clerical and General Office	WeightedCensus	470,290	14	229,689	226,926	35,375	17,277	2
3	24	Travel and Seminar	WeightedCensus	470,290	14	13,239		35,375	996	3
4	25	Other Admin. Staff Transport.	WeightedCensus	470,290	14	6,938		35,375	522	4
5	26	Insurance-Prop./Liab./Malprac.	WeightedCensus	470,290	14	2,943		35,375	221	5
6	27	Mgmt. Allocation of Benefits	WeightedCensus	470,290	14	24,684		35,375	1,857	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					$ 281,473	$ 226,926		$ 21,172	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Moline # 0049304 Report Period Beginning: 07/01/2014 Ending: 6/30/2015

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	WeightedCensus	470,290	14	4,237		35,375	$ 319	1
2	6	Maintenance	WeightedCensus/Direct Exp	470,290	14	513,005	471,253	35,375	37,753	2
3	7	Mgmt. Allocation of Benefits	WeightedCensus	470,290	14	60,169		35,375	4,526	3
4	19	Professional Services	WeightedCensus	470,290	14	123		35,375	9	4
5	21	Clerical and General Office	WeightedCensus	470,290	14	10,353		35,375	779	5
6	24	Travel and Seminar	WeightedCensus	470,290	14	46,417		35,375	3,491	6
7	25	Other Admin. Staff Transport.	WeightedCensus	470,290	14	41,082		35,375	3,090	7
8	26	Insurance-Prop./Liab./Malprac.	WeightedCensus	470,290	14	12,112		35,375	911	8
9	30	Depreciation	WeightedCensus	470,290	14	16,668		35,375	1,254	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					$ 704,166	$ 471,253		$ 52,132	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Moline # 0049304 Report Period Beginning: 07/01/2014 Ending: 6/30/2015

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional Services	WeightedCensus	470,290	14	2,380,463		35,375	$ 179,057	1
2	20	Fees & Subscriptions	WeightedCensus	470,290	14	901		35,375	68	2
3	21	Clerical and General Office	WeightedCensus	470,290	14	12,160		35,375	915	3
4	24	Travel and Seminar	WeightedCensus	470,290	14	3,989		35,375	300	4
5	25	Other Admin. Staff Transport.	WeightedCensus	470,290	14	4,094		35,375	308	5
6	26	Insurance-Prop./Liab./Malprac.	WeightedCensus	470,290	14	9,723		35,375	731	6
7	32	Interest	WeightedCensus	470,290	14	255,901		35,375	19,249	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					$ 2,667,231	$		$ 200,628	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Moline # 0049304 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Berkadia			Mortgage	$87,636.51	11/1/05	$ 6,524,600	$ 11,854,933	12/1/40	0.0480	$ 286,120	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MidCap (Thru Allocation of		X	Revolving Line of Credit		8/1/09			12/31/15	5.0000	71,037	6
7	Bravo Holding Co.)											7
8												8
9	TOTAL Facility Related				$87,636.51		$ 6,524,600	$ 11,854,933			$ 357,157	9
	B. Non-Facility Related*											
10							Less: Interest Income Offset				(3,002)	10
11							Amortization Expense				5,914	11
12							Allocated from Mgmt Co's				32,904	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 35,816	14
15	TOTALS (line 9+line14)						$ 6,524,600	$ 11,854,933			$ 392,973	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 28,206 **Line #** 36

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rosewood Care Ctr of Moline # 0049304 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 124,378	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	See Below	$ 121,840	2
3. Under or (over) accrual (line 2 minus line 1).		$ (2,538)	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 126,916	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.		$ 124,378	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	121,815	8
Taxes Paid-2013 91,455	2011	122,594	9
Taxes Paid-2014 30,385	2012	121,315	10
Total Taxes Paid 121,840	2013	121,940	11
	2014	121,543	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rosewood Care Ctr of Moline COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0049304

CONTACT PERSON REGARDING THIS REPORT Mary Offner

TELEPHONE (314) 994-9070 FAX #: (314) 994-9912

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

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	07-649-95-00	7300 34th Ave. parcel #13991	$ 101,245.92	$ 101,245.92
2.	07-649-94-00	Parcel #13990	$ 20,296.36	$ 20,296.36
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 121,542.28	$ 121,542.28

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

Facility Name & ID Number Rosewood Care Ctr of Moline # 0049304 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,200 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: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	4.4 Acres	1989	$ 1,051,115	1
2					2
3	TOTALS	#VALUE!		$ 1,051,115	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Moline # 0049304 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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		1990	1990	$ 3,036,895	$	40	$ 75,922	$ 75,922	$ 1,910,713	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements - Real Estate Entity										9
10											10
11	Site Improvements			1990	298,795		25	9,878	9,878	298,796	11
12	Walk-in Cooler			1990	7,845		10			7,845	12
13	Sinks			1990	6,386		10			6,386	13
14	Exhaust Hood w/ Fire Extinguisher			1990	6,317		10			6,317	14
15	Generator			1990	15,779		10			15,779	15
16	Signage			1990	2,721		10			2,721	16
17	Facility Signs			1990	1,757		10			1,757	17
18	Cubicle Curtain Track			1990	6,176		10			6,176	18
19	Fire Alarm System			1990	99,726		10			99,726	19
20	Hot Water Heater			1990	6,706		10			6,706	20
21	Water Heater Tank			1990	7,961		10			7,961	21
22	Wallcovering			1990	24,650		10			24,650	22
23	Carpeting			1990	8,025		10			8,025	23
24	Curbing			1991	2,743		25	110	110	2,688	24
25	Landscaping			1991	4,560		25	182	182	4,362	25
26	Steel Trash Doors			1991	1,825		10			1,825	26
27	Irrigation System			1993	10,257		25	410	410	8,992	27
28	Water Meter & Back			1993	1,803		25	72	72	1,575	28
29	Parking Lot Addition			2000	11,485		25	459	459	6,737	29
30	Seal & Restripe Parking Lot			2003	4,530		25	181	181	2,144	30
31	Shingle Roof Replacement			2005	24,958		40	624	624	6,552	31
32	Parking Lot Improvements			2005	16,350		40	409	409	4,054	32
33	Backflow Preventer			2005	6,285		10	629	629	6,024	33
34	Console Heat Pumps			2006	6,337		10	634	634	5,915	34
35	Door Closers			2006	2,603		10	260	260	2,472	35
36	Carpet			2007	5,464		10	546		4,553	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Moline # 0049304 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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	Building Improvements - Real Estate Entity, continued		$	$		$	$	$	37
38									38
39	Seal and Stripe Parking Lot	2008	3,715		25	149	149	1,041	39
40	Telephone System	2008	20,911		10	2,091	2,091	14,986	40
41	Doors	2009	5,097		10	510	510	3,186	41
42	Grease Trap	2009	4,875		10	488	488	3,088	42
43	New Windows	2009	2,625		10	262	262	1,509	43
44	Replace Sidewalks	2009	10,980		25	439	439	2,598	44
45	Carpet - office, resident lounge, dining room & waiting areas	2010	11,593		10	1,159	1,159	6,376	45
46	Doors - Rooms 201, 405, 534 & 535	2010	4,402		10	440	440	2,237	46
47	Countertops in beverage room and therapy room	2010	2,570		10	257	257	1,306	47
48	Sealcoat Parking Lot	2010	4,855		25	194	194	987	48
49	HVAC	2010	3,035		10	303	303	1,416	49
50	Sinks	2011	7,968		10	796	796	2,226	50
51	Crack Repair & control joint caulking entire building	2011	24,950		40	624	624	2,391	51
52	Sprinkler System	2011	8,427		10	842	842	3,107	52
53	Doors - Exterior	2011	29,823		10	2,982	2,982	11,183	53
54	HVAC	2012	28,173		10	2,817	2,817	9,860	54
55	Doors - Exterior	2012	3,096		10	310	310	1,007	55
56	Nurse Call System	2012	3,256		10	326	326	1,059	56
57	Hot Water Boiler	2012	9,404		40	235	235	692	57
58	Seal Coat Parking Lot	2012	6,678		25	267	267	757	58
59	HVAC Improvements	2014	5,301		10	530	530	662	59
60	Seal Coating	2014	5,595		25	168	168	168	60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,836,268	$		$ 106,505	$ 105,959	$ 2,533,293	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rosewood Care Ctr of Moline # 0049304 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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		$ 3,836,268	$		$ 106,505	$ 106,505	$ 2,533,293	1
2	Leasehold Improvements - Operating Entity								2
3									3
4	Tile Repair	2008	2,540	212	7	212		2,540	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)		$ 3,838,808	$ 212		$ 106,717	$ 106,505	$ 2,535,833	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rosewood Care Ctr of Moline # 0049304 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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	$ 58,097	$ 11,619	$ 11,619	$	5	$ 25,114	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Allocated from Mgmt Co/Real Estate Entity	838,518		35,711	35,711		780,551	74
75	TOTALS	$ 896,615	$ 11,619	$ 47,330	$ 35,711		$ 805,665	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,786,538	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 11,831	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 154,047	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 142,216	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,341,498	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	N/A				87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rosewood Care Ctr of Moline # 0049304 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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								5
6	Allocated from Mgmt Co's				12,725			6
7	TOTAL				$ 12,725 **			7

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

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

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 27,876 Description: Offsite Storage - $1,868, Medical Equipment - $23,751, Home Office Allocation - $2,257
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Moline # 0049304 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Moline # 0049304 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	6,093	$ 286,350	$	6,093	$ 286,350	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,439	93,525		1,439	93,525	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		6,594	296,742	1,090	6,594	297,832	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				233,236		233,236	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	14,126	$ 676,617	$ 234,326	14,126	$ 910,943	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Moline # 0049304 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2015 (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	$ (54,688)	$ (50,637)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 349,000)	1,540,352	1,540,352	3
4	Supply Inventory (priced at Cost)	3,661	3,661	4
5	Short-Term Investments			5
6	Prepaid Insurance	25,858	29,214	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,515,183	$ 1,522,590	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,051,115	13
14	Buildings, at Historical Cost		3,036,895	14
15	Leasehold Improvements, at Historical Cost	2,540	801,913	15
16	Equipment, at Historical Cost	58,097	896,615	16
17	Accumulated Depreciation (book methods)	(27,654)	(3,341,498)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		131,080	21
22	Other Long-Term Assets (spe Loan Fees		232,855	22
23	Other(specify): Deposits	2,000	2,000	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 34,983	$ 2,810,975	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,550,166	$ 4,333,565	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 743,409	$ 749,552	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	110,724	110,724	30
31	Accrued Taxes Payable (excluding real estate taxes)	54,528	54,528	31
32	Accrued Real Estate Taxes(Sch.IX-B)		126,916	32
33	Accrued Interest Payable		6,894	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	9,067	27,097	35
	Other Current Liabilities(specify):			
36	Accrued Expenses	501,616	512,816	36
37	Accrued Rent	931,518	(1,934)	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,350,862	$ 1,586,593	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,854,933	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to Bravo Holding Company	526,207	526,207	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 526,207	$ 12,381,140	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,877,069	$ 13,967,733	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,326,903)	$ (9,634,168)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,550,166	$ 4,333,565	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Rosewood Care Ctr of Moline # 0049304 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,848,686)	1	
2	Restatements (describe):		2	
3	**Prior period post closing adjustments**	(2,567)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,851,253)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	524,350	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)**	$ 524,350	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,326,903)	24	*

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Moline # 0049304 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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	$ 9,171,898	1
2	Discounts and Allowances for all Levels	(1,914,760)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,257,138	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	251,780	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 251,780	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,200	13
14	Non-Patient Meals	6,547	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	79,350	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 88,097	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,971	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,971	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached Schedule 19A	5,623	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,623	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,605,609	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,111,237	31
32	Health Care	2,733,809	32
33	General Administration	1,203,713	33
	B. Capital Expense		
34	Ownership	1,359,901	34
	C. Ancillary Expense		
35	Special Cost Centers	428,757	35
36	Provider Participation Fee	243,842	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,081,259	40
41	**Income before Income Taxes (line 30 minus line 40)****	524,350	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 524,350	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,302,315	44
45	Private Pay - Net Inpatient Revenue	2,016,954	45
46	Medicare - Net Inpatient Revenue	2,253,877	46
47	Other-(specify) Insurance/Managed Care	683,992	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,257,138	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.**

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Care Ctr of Moline

Period Beginning 07/01/2014
Period End 06/30/2015

Schedule 19A

Other Revenue:

Vending Income	**1,426**
Vendor Discount	**3,898**
Miscellaneous	**299**
Total Other Revenue	**5,623**

Facility Name & ID Number Rosewood Care Ctr of Moline # 0049304 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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	2,162	2,348	$ 66,871	$ 28.48	1
2	Assistant Director of Nursing	1,984	2,096	47,897	22.85	2
3	Registered Nurses	9,369	10,069	195,295	19.40	3
4	Licensed Practical Nurses	24,679	26,084	431,417	16.54	4
5	CNAs & Orderlies	77,684	80,542	798,796	9.92	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,160	2,348	25,454	10.84	9
10	Activity Assistants	2,995	3,132	26,372	8.42	10
11	Social Service Workers	3,746	4,005	40,355	10.08	11
12	Dietician					12
13	Food Service Supervisor	2,230	2,628	49,335	18.77	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,859	22,562	199,737	8.85	15
16	Dishwashers					16
17	Maintenance Workers	2,269	2,414	31,790	13.17	17
18	Housekeepers	1,135	1,883	18,717	9.94	18
19	Laundry	393	542	4,829	8.91	19
20	Administrator	2,160	2,224	89,539	40.26	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,892	8,268	77,011	9.31	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,947	3,110	30,298	9.74	31
32	Other Health Care(specify)					32
33	Other(specify) See Sch 20A	12,373	13,344	241,170	18.07	33
34	TOTAL (lines 1 - 33)	177,037	187,599	$ 2,374,883 *	$ 12.66	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 9,280	L1, C3	35
36	Medical Director	Monthly	18,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,662	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,800	L11, C3	44
45	Social Service Consultant	Monthly	1,800	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 39,542		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	477	19,062	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	477	$ 19,062		53

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Care Ctr of Moline

Period Beginning 07/01/2014
Period End 06/30/2015

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Nurse	**2,137**	**2,221**	**44,073**	19.84
Case Manager	**2,176**	**2,338**	**47,205**	20.19
Rehabilitation Nurse	**1,691**	**1,864**	**34,600**	18.56
Ward Clerk	**1,983**	**2,079**	**31,607**	15.20
Marketing	**4,386**	**4,842**	**83,685**	17.28
TOTAL	**12,373**	**13,344**	**241,170**	

Facility Name & ID Number Rosewood Care Ctr of Moline # 0049304 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Chad Joe Coulter	Administrator	0	$ 89,539
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 89,539

B. Administrative - Other

Description	Amount
Mgmt Fees-Bravo Nursing Home Svc-See Pg 6, Elimon P 3, C 7	$ 138,000
Mgmt Fees-Midwest Admin Svc-See Pg 6, Elim on P 3, C 7	214,685
TOTAL (agree to Schedule V, line 17, col. 3)	$ 352,685
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Hochschild, Bloom & Company	Accountant/Consultant	$ 3,120
WestLaw	Computer Consulting	1,553
Odessa Healthcare	Consultant	75,303
Claims Administration Services, Inc.	Related Party Legal Fees	8,687
Daniel Maher	Legal Fees	6,783
US Legal Support, Inc	Record Copying	733
Rock Island County Circuit Court	Legal-Court Costs	242
Various	Various below $200	390
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 96,811

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 67,093
Unemployment Compensation Insurance	104,068
FICA Taxes	179,656
Employee Health Insurance	30,535
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	2,609
Employee Uniforms	596
Employee Physicals	2,074
Employee Drug Tests	483
401K Expense	365
TOTAL (agree to Schedule V, line 22, col.8)	$ 387,479

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,865
Health Care Worker Background Check	
(Indicate # of checks performed 387)	4,260
Patient Background Checks	
Misc. Dues/Subscriptions/Fees	422
IHCA Dues	2,117
Misc. Licenses	798
Home Office Allocation	7,720
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,182

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Home Office Allocation	10,625
Seminar Expense	206
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,831

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Moline # 0049304 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Moline # 0049304 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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. **2,117 IHCA**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(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**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **56,279** 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. $ **243,842**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **7,973**

(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.