FOR BHF USE

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

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

I. IDPH License ID Number: 0049304

Facility Name: Rosewood Care Center 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: [redacted]

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: 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 Moline # 0049304 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	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	17,931	8,117	3,698	29,746	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,931	8,117	3,698	29,746	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.91%

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 12/01/07

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/01/07 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 1,698

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: 6/30/2017 Fiscal Year: 6/30/2017

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

Facility Name & ID Number Rosewood Care Center Of Moline # 0049304 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		1,247	415,609	416,856		416,856		416,856			1
2	Food Purchase		199,001		199,001		199,001	(7,361)	191,640			2
3	Housekeeping		17,158	152,475	169,633		169,633		169,633			3
4	Laundry			101,650	101,650		101,650		101,650			4
5	Heat and Other Utilities			146,020	146,020		146,020	(9,856)	136,164			5
6	Maintenance	34,863	6,095	219,421	260,379		260,379	(38,301)	222,078			6
7	Other (specify):*							2,654	2,654			7
8	TOTAL General Services	34,863	223,501	1,035,175	1,293,539		1,293,539	(52,864)	1,240,675			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	1,380,944	198,677	718,658	2,298,279		2,298,279	34,191	2,332,470			10
10a	Therapy	73,690	1,469		75,159		75,159		75,159			10a
11	Activities	44,698	4,224	2,600	51,522		51,522		51,522			11
12	Social Services	49,923		2,600	52,523		52,523		52,523			12
13	CNA Training											13
14	Program Transportation			90	90		90		90			14
15	Other (specify):*							2,373	2,373			15
16	TOTAL Health Care and Programs	1,549,255	204,370	738,348	2,491,973		2,491,973	36,564	2,528,537			16
	C. General Administration											
17	Administrative	84,241		290,159	374,400		374,400	(260,265)	114,135			17
18	Directors Fees											18
19	Professional Services			100,306	100,306		100,306	20,117	120,423			19
20	Dues, Fees, Subscriptions & Promotions			27,368	27,368		27,368	(232)	27,136			20
21	Clerical & General Office Expenses	92,042	19,205	299,801	411,048		411,048	(105,218)	305,830			21
22	Employee Benefits & Payroll Taxes			267,927	267,927		267,927		267,927			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,168	3,168		3,168	1,297	4,465			24
25	Other Admin. Staff Transportation			8,134	8,134		8,134	6,051	14,185			25
26	Insurance-Prop.Liab.Malpractice			80,800	80,800		80,800	13,379	94,179			26
27	Other (specify):*							24,391	24,391			27
28	TOTAL General Administration	176,283	19,205	1,077,663	1,273,151		1,273,151	(300,480)	972,671			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,760,401	447,076	2,851,186	5,058,663		5,058,663	(316,780)	4,741,883			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 Moline #0049304 **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			11,620	11,620		11,620	127,984	139,604			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			136,734	136,734		136,734	523,337	660,071			32
33	Real Estate Taxes							127,199	127,199			33
34	Rent-Facility & Grounds			1,125,140	1,125,140		1,125,140	(1,107,959)	17,181			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			16,777	16,777		16,777	41,960	58,737			36
37	**TOTAL Ownership**			1,290,271	1,290,271		1,290,271	(287,479)	1,002,792			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		156,467	591,070	747,537		747,537		747,537			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			239,171	239,171		239,171		239,171			42
43	Other (specify):*	76,394		2,449	78,843		78,843	(78,843)	(0)			43
44	**TOTAL Special Cost Centers**	76,394	156,467	832,690	1,065,551		1,065,551	(78,843)	986,708			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,836,795	603,543	4,974,147	7,414,485		7,414,485	(683,101)	6,731,384			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 Moline # 0049304 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	(5,807)	02		4
5	Telephone, TV & Radio in Resident Rooms	(10,191)	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	4,588	30		9
10	Interest and Other Investment Income	(12,787)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(543)	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	(10,989)	21		18
19	Entertainment	(224)	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	(226,156)	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	(249)	20		28
29	Other-Attach Schedule	(195,391)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (457,749)		$	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)	(225,352)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (225,352)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (683,101)		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 Moline

ID# 0049304

Report Period Beginning: 07/01/16

Ending: 06/30/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Allowable Travel	$ (4,173)	25	1
2	Marketing Salary	(76,394)	43	2
3	Marketing	(2,449)	43	3
4	Bank Charges	(2,011)	21	4
5	Vending Income	(1,011)	02	5
6	Vendor Discount	(6,075)	21	6
7	Miscellaneous Income	(132)	21	7
8	Midcap Line of Credit Fees	(16,777)	36	8
9	Vendor Late Charges	(29,247)	21	9
10	Capitalized R&M	(20,396)	06	10
11	PAC Dues	(2,918)	20	11
12	Court Filing Fee	(155)	21	12
13	Non-Allowable Legal	(1,991)	19	13
14	Building Co. - Audit Fees	(9,720)	19	14
15	Building Co. - Bank Charges	(16,028)	21	15
16	Building Co. - Amortization Loan Fee	(5,914)	36	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**	(195,391)		49

Rosewood Care Center Of Moline

ID# 0049304

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 Moline **#** 0049304 **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	(7,361)											(7,361)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(10,191)					224	112					(9,856)	5
6	Maintenance	(20,396)					97	(18,002)					(38,301)	6
7	Other (specify):*							2,654					2,654	7
8	**TOTAL General Services**	(37,948)					321	(15,236)					(52,864)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				34,191								34,191	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				2,373								2,373	15
16	**TOTAL Health Care and Programs**				36,564								36,564	16
	C. General Administration													
17	Administrative				(108,106)		(152,159)						(260,265)	17
18	Directors Fees													18
19	Professional Services	(11,711)	9,720	14,068	341	7,699							20,117	19
20	Fees, Subscriptions & Promotions	(3,167)			4	152	2,725	54					(232)	20
21	Clerical & General Office Expenses	(291,017)	23,228		799	23,505	137,905	361					(105,218)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			726	112	325	134						1,297	24
25	Other Admin. Staff Transportation	(4,173)			2,793	2,248	3,326	1,858					6,051	25
26	Insurance-Prop.Liab.Malpractice		8,873				4,015	491					13,379	26
27	Other (specify):*				3,231	2,735	18,425						24,391	27
28	**TOTAL General Administration**	(310,068)	41,821	14,795	(100,827)	36,664	14,372	2,764					(300,480)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(348,016)	41,821	14,795	(64,263)	36,664	14,693	(12,473)					(316,780)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Center Of Moline # 0049304 **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	4,588	112,147				10,929	320					127,984	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(12,787)	548,777	(32,460)			19,807						523,337	32
33	Real Estate Taxes		127,199										127,199	33
34	Rent-Facility & Grounds		(1,123,202)				15,244						(1,107,959)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*	(22,691)	64,651										41,960	36
37	**TOTAL Ownership**	(30,890)	(270,428)	(32,460)			45,979	320					(287,479)	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):*	(78,843)											(78,843)	43
44	**TOTAL Special Cost Centers**	(78,843)											(78,843)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(457,749)	(228,607)	(17,665)	(64,263)	36,664	60,671	(12,152)					(683,101)	45

Facility Name & ID Number Rosewood Care Center Of Moline # 0049304 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	$ 1,123,202	Moline Real Estate, LLC		$	$ (1,123,202)	1
2	V	32	Interest Income - Escrow	17	Moline Real Estate, LLC			(17)	2
3	V	19	Audit Fees		Moline Real Estate, LLC		9,720	9,720	3
4	V	21	Bank Charges		Moline Real Estate, LLC		16,028	16,028	4
5	V	32	Interest Expense - HUD Mortgage		Moline Real Estate, LLC		548,794	548,794	5
6	V	36	Interest Expense - HUD MIP		Moline Real Estate, LLC		58,738	58,738	6
7	V	33	Real Estate Tax		Moline Real Estate, LLC		127,199	127,199	7
8	V	30	Depreciation		Moline Real Estate, LLC		112,147	112,147	8
9	V	36	Amortization Loan Fee		Moline Real Estate, LLC		5,914	5,914	9
10	V	21	Base Admin Fee (Page 6D)		Moline Real Estate, LLC		7,200	7,200	10
11	V	26	Insurance Expense - Property		Moline Real Estate, LLC		8,873	8,873	11
12	V								12
13	V								13
14	Total			$ 1,123,219			$ 894,612	$ * (228,607)	14

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

Facility Name & ID Number Rosewood Care Center Of Moline # 0049304 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%	$ 14,068	$ 14,068	15
16	V	24	SEMINAR EXPENSE		BRAVO HOLDING COMPANY	100.00%	726	726	16
17	V	32	INTEREST		BRAVO HOLDING COMPANY	100.00%	(32,460)	(32,460)	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			$			$ (17,665)	$ * (17,665)	39

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

Facility Name & ID Number Rosewood Care Center Of Moline # 0049304 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%	$ 34,191	$ 34,191	15
16	V	15	CORPORATE RN SALARIES BENEFITS		BRAVO NURSING HOME SERVICES, INC.	100.00%	2,373	2,373	16
17	V	17	ADMINISTRATIVE SALARIES		BRAVO NURSING HOME SERVICES, INC.	100.00%	29,894	29,894	17
18	V	19	PROFESSIONAL FEES		BRAVO NURSING HOME SERVICES, INC.	100.00%	341	341	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%	799	799	20
21	V	24	SEMINAR & LODGING EXPENSE		BRAVO NURSING HOME SERVICES, INC.	100.00%	112	112	21
22	V	25	AUTO EXPENSE		BRAVO NURSING HOME SERVICES, INC.	100.00%	2,793	2,793	22
23	V	27	ADMINISTRATIVE & OFFICE BENEFITS		BRAVO NURSING HOME SERVICES, INC.	100.00%	3,231	3,231	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			$ 73,737	$ * (64,263)	39

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

Facility Name & ID Number Rosewood Care Center Of Moline # 0049304 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%	$ 2,062	$ 2,062	15
16	V	20	LICENSES		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	152	152	16
17	V	21	LEGAL SALARIES		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	23,192	23,192	17
18	V	21	OFFICE EXPENSE		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	313	313	18
19	V	24	SEMINAR		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	325	325	19
20	V	25	AUTO / TRAVEL EXPENSE		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	2,248	2,248	20
21	V	27	EMPLOYEE BENEFITS		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	2,735	2,735	21
22	V								22
23	V	19	PROFESSIONAL FEES	(5,637)	CLAIMS ADMINISTRATION SERVICES, LLC	100.00%		5,637	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ (5,637)			$ 31,027	$ * 36,664	39

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

Facility Name & ID Number Rosewood Care Center Of Moline # 0049304 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%	$ 224	$ 224	15
16	V	6	MAINTENANCE EXPENSE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	97	97	16
17	V	20	DUES, SUBSCRIPTIONS, LICENSES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	2,725	2,725	17
18	V	21	OFFICE SALARIES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	109,730	109,730	18
19	V	21	OFFICE EXPENSES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	35,375	35,375	19
20	V	24	SEMINAR		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	134	134	20
21	V	25	TRAVEL EXPENSE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	3,326	3,326	21
22	V	26	INSURANCE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	4,015	4,015	22
23	V	27	EMPLOYEE BENEFITS		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	18,425	18,425	23
24	V	30	DEPRECIATION		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	10,929	10,929	24
25	V	32	INTEREST		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	19,807	19,807	25
26	V	34	BUILDING RENT		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	15,244	15,244	26
27	V								27
28	V								28
29	V	17	ADMINISTRATIVE FEE	152,159	MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%		(152,159)	29
30	V	21	ADMINISTRATIVE FEE (BLDG CO)	7,200	MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%		(7,200)	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			$ 159,359			$ 220,030	$ * 60,671	39

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

Facility Name & ID Number Rosewood Care Center Of Moline # 0049304 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%	$ 112	$ 112	15
16	V	6	MAINTENANCE SALARY		SENIOR LIVING SERVICES, INC.	100.00%	17,670	17,670	16
17	V	6	MAINTENANCE EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	1,584	1,584	17
18	V	7	MAINTENANCE BENEFITS		SENIOR LIVING SERVICES, INC.	100.00%	2,654	2,654	18
19	V	20	LICENSES		SENIOR LIVING SERVICES, INC.	100.00%	54	54	19
20	V	21	OFFICE EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	361	361	20
21	V	25	AUTO / TRAVEL EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	1,858	1,858	21
22	V	26	INSURANCE		SENIOR LIVING SERVICES, INC.	100.00%	491	491	22
23	V	30	DEPRECIATION		SENIOR LIVING SERVICES, INC.	100.00%	320	320	23
24	V								24
25	V	6	MAINTENANCE SERVICES	37,277	SENIOR LIVING SERVICES, INC.	100.00%	21	(37,256)	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			$ 37,277			$ 25,125	$ * (12,152)	39

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

Facility Name & ID Number Rosewood Care Center Of Moline # 0049304 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 Moline # 0049304 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 Moline # 0049304 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 Moline # 0049304 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 Moline # 0049304 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	Moline Real Estate, LLC	Moline, IL	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 Galesburg, Inc.	Galesburg, 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 Northbrook, Inc.	Northbrook, 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 Moline # 0049304 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 Moline # 0049304 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											11
12											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 Moline # 0049304 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 Moline # 0049304 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	$	29,746	$ 14,068	1
2	24	SEMINAR EXPENSE	PATIENT DAYS	445,412	14	10,876		29,746	726	2
3	32	INTEREST	PATIENT DAYS	445,412	14	(486,047)		29,746	(32,460)	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)	$		$ (17,665)	25

Facility Name & ID Number Rosewood Care Center Of Moline # 0049304 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	29,746	$ 34,191	1
2	15	CORPORATE RN SALARIES BE	PAT. DAYS	445,412	14	35,539		29,746	2,373	2
3	17	ADMINISTRATIVE SALARIES	PAT. DAYS	445,412	14	447,622	447,622	29,746	29,894	3
4	19	PROFESSIONAL FEES	PAT. DAYS	445,412	14	5,100		29,746	341	4
5	20	DUES & SUBSCRIPTIONS	PAT. DAYS	445,412	14	53		29,746	4	5
6	21	OFFICE EXPENSES	PAT. DAYS	445,412	14	11,963		29,746	799	6
7	24	SEMINAR & LODGING EXPEN	PAT. DAYS	445,412	14	1,683		29,746	112	7
8	25	AUTO EXPENSE	PAT. DAYS	445,412	14	41,816		29,746	2,793	8
9	27	ADMINISTRATIVE & OFFICE I	PAT. DAYS	445,412	14	48,387		29,746	3,231	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		$ 73,737	25

Facility Name & ID Number Rosewood Care Center Of Moline # 0049304 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	$	57,825	$ 2,062	1
2	20	LICENSES	ACTUAL FEES	439,804	14	1,155		57,825	152	2
3	21	LEGAL SALARIES	ACTUAL FEES	439,804	14	176,396	176,396	57,825	23,192	3
4	21	OFFICE EXPENSE	ACTUAL FEES	439,804	14	2,382		57,825	313	4
5	24	SEMINAR	ACTUAL FEES	439,804	14	2,470		57,825	325	5
6	25	AUTO / TRAVEL EXPENSE	ACTUAL FEES	439,804	14	17,094		57,825	2,248	6
7	27	EMPLOYEE BENEFITS	ACTUAL FEES	439,804	14	20,803		57,825	2,735	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		$ 31,027	25

Facility Name & ID Number Rosewood Care Center Of Moline # 0049304 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	$	29,746	$ 224	1
2	6	MAINTENANCE EXPENSE	PAT. DAYS	445,412	14	1,452		29,746	97	2
3	20	DUES, SUBSCRIPTIONS, LICEN	PAT. DAYS	445,412	14	40,807		29,746	2,725	3
4	21	OFFICE SALARIES	PAT. DAYS	445,412	14	1,643,080	1,643,080	29,746	109,730	4
5	21	OFFICE EXPENSES	PAT. DAYS	445,412	14	529,702		29,746	35,375	5
6	24	SEMINAR	PAT. DAYS	445,412	14	2,006		29,746	134	6
7	25	TRAVEL EXPENSE	PAT. DAYS	445,412	14	49,808		29,746	3,326	7
8	26	INSURANCE	PAT. DAYS	445,412	14	60,126		29,746	4,015	8
9	27	EMPLOYEE BENEFITS	PAT. DAYS	445,412	14	275,890		29,746	18,425	9
10	30	DEPRECIATION	PAT. DAYS	445,412	14	163,642		29,746	10,929	10
11	32	INTEREST	PAT. DAYS	445,412	14	296,581		29,746	19,807	11
12	34	BUILDING RENT	PAT. DAYS	445,412	14	228,258		29,746	15,244	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		$ 220,030	25

Facility Name & ID Number Rosewood Care Center Of Moline # 0049304 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	$	37,277	$ 112	1
2	6	MAINTENANCE SALARY	ACTUAL FEES	931,614	14	441,618	441,618	37,277	17,670	2
3	6	MAINTENANCE EXPENSE	ACTUAL FEES	931,614	14	39,580		37,277	1,584	3
4	7	MAINTENANCE BENEFITS	ACTUAL FEES	931,614	14	66,326		37,277	2,654	4
5	20	LICENSES	ACTUAL FEES	931,614	14	1,361		37,277	54	5
6	21	OFFICE EXPENSE	ACTUAL FEES	931,614	14	9,024		37,277	361	6
7	25	AUTO / TRAVEL EXPENSE	ACTUAL FEES	931,614	14	46,424		37,277	1,858	7
8	26	INSURANCE	ACTUAL FEES	931,614	14	12,265		37,277	491	8
9	30	DEPRECIATION	ACTUAL FEES	931,614	14	8,001		37,277	320	9
10										10
11	6	MAINTENANCE SERVICES	DIRECT ALLOCATION		14	4,421			21	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		$ 25,125	25

Facility Name & ID Number Rosewood Care Center Of Moline # 0049304 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 Moline # 0049304 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 Moline # 0049304 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 Moline # 0049304 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 Moline # 0049304 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	Berkadia		X	Mortgage	$87,636.51	11/1/05	$ 6,524,600	$ 11,615,408	12/1/40	0.0480	$ 548,794	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Midcap		X	Revolving Line of Credit							136,734	6
7	Bravo Holding		X	Note Payable				237,281			(12,766)	7
8	See Supplemental Schedule										19,807	8
9	TOTAL Facility Related				$87,636.51		$ 6,524,600	$ 11,852,689			$ 692,569	9
	B. Non-Facility Related*											
10	Interest Income		X								(21)	10
11	Interest Income - Bldg Co		X								(17)	11
12	Alloc from Bravo Holding Co		X								(32,460)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (32,498)	14
15	TOTALS (line 9+line14)						$ 6,524,600	$ 11,852,689			$ 660,071	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 58,738 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.)

** 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 Moline **#** 0049304 **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.**	$ 155,439	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.)		$ 126,448	2
3. Under or (over) accrual (line 2 minus line 1).		$ (28,991)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 156,190	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.		$ 127,199	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	121,315	8
	2013	121,940	9
	2014	121,543	10
	2015	124,993	11
	2016	127,903	12

Accrual based on prior year tax bill.

The expense on line 2 is the second installment of 2015 and first installment of 2016 tax bills.

	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 Moline COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0049304

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.	07-649-94-00	Long Term Care Property	$ 21,358.60	$ 21,358.60
2.	07-649-95-00	Long Term Care Property	$ 106,544.72	$ 106,544.72
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 127,903.32	$ 127,903.32

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 Moline COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0049304

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 Moline # 0049304 Report Period Beginning: 07/01/16 Ending: 06/30/17

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. [ ] (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	Facility	4.4 Acres	1989	$ 1,051,115	1
2					2
3	TOTALS			$ 1,051,115	3

Facility Name & ID Number Rosewood Care Center Of Moline # 0049304 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		1990	1990	$ 3,122,410	$ 112,147	40	$ 78,060	$ (34,087)	$ 2,066,833	4
5											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 Moline # 0049304 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)		626,878			19,709	19,709	478,414	67
68	Related Party Allocations (Pages 12H & 12I)		157	31		31		31	68
69	Financial Statement Depreciation			11,620			(11,620)		69
70	TOTAL (lines 4 thru 69)		$ 3,749,445	$ 123,798		$ 97,800	$ (25,998)	$ 2,545,278	70

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

Facility Name & ID Number Rosewood Care Center Of Moline # 0049304 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		$ 3,749,445	$ 123,798		$ 97,800	$ (25,998)	$ 2,545,278	1
2	Rewire Therapy Kitchen, Power Feed For Irrigation Pump	2016	3,472		20	174	174	348	2
3	Wiring-Kitch/Leak Repair - Dining Room/Changed Blower Belt	2016	4,954		20	198	198	198	3
4	Pipe Leak Repair	2016	2,614		20	105	105	105	4
5	Dry System Leak Repair	2017	5,728		20	229	229	229	5
6	Air Compressor Repair	2017	3,680		20	147	147	147	6
7	Remove Old Pendants And Install New Replacements	2017	3,420		20	137	137	137	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)		$ 3,773,313	$ 123,798		$ 98,790	$ (25,008)	$ 2,546,442	34

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

Facility Name & ID Number Rosewood Care Center Of Moline # 0049304 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		$ 3,773,313	$ 123,798		$ 98,790	$ (25,008)	$ 2,546,442	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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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)		$ 3,773,313	$ 123,798		$ 98,790	$ (25,008)	$ 2,546,442	34

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

Facility Name & ID Number Rosewood Care Center Of Moline # 0049304 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		$ 3,773,313	$ 123,798		$ 98,790	$ (25,008)	$ 2,546,442	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)		$ 3,773,313	$ 123,798		$ 98,790	$ (25,008)	$ 2,546,442	34

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

Facility Name & ID Number Rosewood Care Center Of Moline # 0049304 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		$ 3,773,313	$ 123,798		$ 98,790	$ (25,008)	$ 2,546,442	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,773,313	$ 123,798		$ 98,790	$ (25,008)	$ 2,546,442	34

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

Facility Name & ID Number Rosewood Care Center Of Moline # 0049304 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	Site Improvements	1990	184,272		25			184,272	9
10	Walk-In Cooler	1990	7,845		10			7,845	10
11	Sinks	1990	3,103		10			3,103	11
12	Exhaust Hood	1990	4,670		10			4,670	12
13	Generator	1990	15,779		10			15,779	13
14	Fire Alarm System	1990	99,726		10			99,726	14
15	Curbing	1991	2,743		25			2,743	15
16	Landspcaping	1991	4,560		25			4,560	16
17	Irrigation System	1993	10,257		25	410	410	9,812	17
18	Water Meter & Back	1993	1,803		25	72	72	1,719	18
19	Parking Lot Addition	2000	11,485		25	459	459	7,655	19
20	Seal & Restripe Parking Lot	2003	4,530		25	181	181	2,506	20
21	Shingle Roof Replacement	2005	24,958		40	624	624	7,800	21
22	Parking Lot Improvements	2005	16,350		40	409	409	4,872	22
23	Console Heat Pumps	2006	6,337		10			6,337	23
24	Door Closers	2006	2,603		10			2,603	24
25	Carpet	2007	5,464		10			5,464	25
26	Seal & Stripe Parking Lot	2008	3,715		25	149	149	1,339	26
27	Telephone System	2008	20,911		10	2,091	2,091	19,168	27
28	Doors	2009	5,097		10	510	510	4,206	28
29	Grease Trap	2009	4,875		10	488	488	4,064	29
30	New Windows	2009	2,625		10	263	263	2,034	30
31	Replace Sidewalks	2009	10,980		25	439	439	3,476	31
32	Carpet - Office, Resident Lounge, Dining Room, Waiting Areas	2010	11,593		10	1,159	1,159	8,694	32
33	Doors - Rooms 201, 405, 534, 535	2010	4,402		10	440	440	3,117	33
34	TOTAL (lines 1 thru 33)		$ 470,683	$		$ 7,694	$ 7,694	$ 417,564	34

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

Facility Name & ID Number Rosewood Care Center Of Moline # 0049304 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		$ 470,683	$		$ 7,694	$	$ 417,564	1
2	Countertops in Beverage Room & Therapy Room	2010	2,570		10	257	257	1,820	2
3	Sealcoat Parking Lot	2010	4,855		25	194	194	1,375	3
4	HVAC	2010	3,035		10	304	304	2,023	4
5	Sinks	2011	7,968		10	797	797	3,819	5
6	Crack, Repair & Control Joint Caulking Entire Building	2011	24,950		40	624	624	3,639	6
7	Sprinkler System	2011	8,427		10	843	843	4,792	7
8	Doors - Exterior	2011	29,823		10	2,982	2,982	17,147	8
9	HVAC	2012	28,173		10	2,817	2,817	15,494	9
10	Doors - Exterior	2012	3,096		10	310	310	1,627	10
11	Nurse Call System	2012	3,256		10	326	326	1,711	11
12	Hot Water Boiler	2012	9,404		40	235	235	1,162	12
13	Sealcoat Parking Lot	2012	6,678		25	267	267	1,291	13
14	HVAC Improvements	2014	5,301		10	530	530	1,722	14
15	Sealcoating	2014	5,595		25	224	224	616	15
16	Cooling Tower	2015	13,064		10	1,306	1,306	2,612	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)		$ 626,878	$		$ 19,709	$ 12,015	$ 478,414	34

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

Facility Name & ID Number Rosewood Care Center Of Moline # 0049304 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	Senior Living Services - Fire Protection System	2017	157	31	5	31		31	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)		$ 157	$ 31		$ 31	$	$ 31	34

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

Facility Name & ID Number Rosewood Care Center Of Moline # 0049304 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		$ 157	$ 31		$ 31	$	$ 31	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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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)		$ 157	$ 31		$ 31	$	$ 31	34

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

Facility Name & ID Number Rosewood Care Center Of Moline # 0049304 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	$ 340,804	$ 2,459	$ 32,055	$ 29,596	10	$ 290,834	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	16,559	87	87		10	16,559	73
74								74
75	TOTALS	$ 357,363	$ 2,546	$ 32,142	$ 29,596		$ 307,393	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		Alloc Midwest Administrative Se	various	$ 44,815	$ 8,382	$ 8,382	$	5	$ 36,889	76
77		Alloc Senior Living Services, Inc.	various	5,989	289	289		5	5,893	77
78										78
79										79
80	TOTALS			$ 50,804	$ 8,671	$ 8,671	$		$ 42,782	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)	$ 5,232,595	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 135,015	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 139,603	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 4,588	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,896,617	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 Moline # 0049304 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 Strorage				1,938			5
6	Allocated from Midwest Administrative Services				15,244			6
7	TOTAL				$ 17,182 **			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 Moline # 0049304 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 Moline # 0049304 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	$		$ 225,732	$		$ 225,732	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			82,264			82,264	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			276,387			276,387	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				147,607		147,607	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					6,687	8,860		15,547	13
14	TOTAL			$		$ 591,070	$ 156,467		$ 747,537	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 Moline **#** 0049304 **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	$ 1,209	$ 1,724	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,727,029	2,727,029	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	49,311	52,619	6
7	Other Prepaid Expenses		221,028	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)**	$ 2,779,549	$ 3,004,400	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		3,112,558	14
15	Leasehold Improvements, at Historical Cost		251,473	15
16	Equipment, at Historical Cost	58,097	627,907	16
17	Accumulated Depreciation (book methods)	(48,354)	(2,820,193)	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)**	$ 9,743	$ 2,222,860	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,789,292	$ 5,227,260	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,437,300	$ 2,516,377	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	237,281	237,281	29
30	Accrued Salaries Payable	101,367	101,367	30
31	Accrued Taxes Payable (excluding real estate taxes)	162,392	162,392	31
32	Accrued Real Estate Taxes(Sch.IX-B)		156,190	32
33	Accrued Interest Payable		1,152,405	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	9,067	25,197	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	2,912,974	533,080	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,860,381	$ 4,884,289	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,615,408	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)**	$	$ 11,615,408	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,860,381	$ 16,499,697	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,071,089)	$ (11,272,437)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,789,292	$ 5,227,260	48

***(See instructions.)**

Facility Name & ID Number Rosewood Care Center Of Moline # 0049304 **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**	$ (1,718,221)	1
2	Restatements (describe):		2
3	Rounding	13	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,718,208)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,352,881)	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)**	$ (1,352,881)	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)**	$ (3,071,089)	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	$ 5,738,422	1
2	Discounts and Allowances for all Levels	(1,458,502)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,279,920	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,513,606	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,513,606	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	1,500	13
14	Non-Patient Meals	5,807	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	185,328	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,178	19
20	Radiology and X-Ray	1,456	20
21	Other Medical Services	46,804	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 248,073	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	12,787	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 12,787	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	7,218	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,218	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,061,604	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,293,539	31
32	Health Care	2,491,973	32
33	General Administration	1,273,151	33
	B. Capital Expense		
34	Ownership	1,290,271	34
	C. Ancillary Expense		
35	Special Cost Centers	826,380	35
36	Provider Participation Fee	239,171	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,414,485	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,352,881)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,352,881)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,435,119	44
45	Private Pay - Net Inpatient Revenue	1,582,549	45
46	Medicare - Net Inpatient Revenue	125,871	46
47	Other-(specify) Insurance/Managed Care	136,381	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,279,920	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	936	1,016	$ 30,846	$ 30.36	1
2	Assistant Director of Nursing	1,222	1,291	32,241	24.97	2
3	Registered Nurses	12,557	13,353	276,740	20.72	3
4	Licensed Practical Nurses	19,484	20,553	364,292	17.72	4
5	CNAs & Orderlies	55,033	59,819	638,991	10.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,658	3,970	73,690	18.56	8
9	Activity Director	2,160	2,298	25,574	11.13	9
10	Activity Assistants	2,178	2,271	19,124	8.42	10
11	Social Service Workers	3,747	4,006	49,923	12.46	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	2,641	2,785	34,863	12.52	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,160	2,224	84,241	37.88	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,891	8,346	92,042	11.03	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	3,586	3,783	37,834	10.00	31
32	Other Health Care(specify)					32
33	Other(specify)	3,409	3,868	76,394	19.75	33
34	TOTAL (lines 1 - 33)	120,662	129,583	$ 1,836,795 *	$ 14.17	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	14,400	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,761	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	2,600	11-03	44
45	Social Service Consultant	Monthly	2,600	12-03	45
46	Other(specify) Outsourced Dietary	Monthly	415,609	01-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 442,970		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	3,040	$ 121,584	10-03	50
51	Licensed Practical Nurses	4,579	183,155	10-03	51
52	Certified Nurse Assistants/Aides	15,621	406,158	10-03	52
53	TOTAL (lines 50 - 52)	23,240	$ 710,897		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Trudy Whittington	Administrator	0	$ 84,241
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 84,241

B. Administrative - Other

Description	Amount
Base Management Fee - Bravo Nursing Home Services	$ 138,000
Base Admin Fee - Midwest Admin Services	36,000
Volume Admin Fee - Midwest Admin Services	116,159
TOTAL (agree to Schedule V, line 17, col. 3)	$ 290,159
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 9,735
Ability Network	Data Processing	6,599
Quality Healthcare Resources	Financial Consulting	25,275
Resolute Healthcare Solutions	Business Operations Mngmt	2,420
Infinite Solutions	IT Solution Provider	23,475
Midwest Litigation Services	Court Reporter	4,356
Huney-Vaughn Court Reporters	Court Reporter	116
Open Delta Consulting	Mngmt Consulting	10,100
Nexus Legal Nurse Consulting	Nurse Consulting	8,313
Clark & Associates	Court Reporter	462
Resolute Systems	Mediation Services	1,395
See Supplemental Schedule		8,062
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 100,306

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 54,239
Unemployment Compensation Insurance	41,111
FICA Taxes	137,222
Employee Health Insurance	29,338
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K Expense	1,637
Employee Physicals & Vaccinations	1,106
Employee Drug Tests	160
Dental Insurance	1,461
Employee Relations	1,652
TOTAL (agree to Schedule V, line 22, col.8)	$ 267,926

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	$
Advertising: Employee Recruitment	3,505
Health Care Worker Background Check	
(Indicate # of checks performed 870)	9,558
Patient Background Checks	
Dues, Fees & Subscriptions	11,138
Alloc from Midwest Admin Services	2,725
Alloc from Bravo Nsg Home Services	4
Alloc from Claims Admin Services	152
See Supplemental Schedule	54
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,136

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,168
Alloc from Bravo Holidng Company	726
Alloc from Bravo Nrsg Home Services	112
See Supplemental Schedule	459
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,465

* Attach copy of IMRF notifications

**See instructions.

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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 $7,386**

(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**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **64,386** 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. $ **239,171**
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. $ **5,807**

(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