FOR BHF USE

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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:

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:** (847) 282-6300
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 07/01/17 to 06/30/18 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(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: 07/01/17 Ending: 06/30/18

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	16,497	7,148	6,345	29,990	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,497	7,148	6,345	29,990	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.47%

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 12/01/2007

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/01/2007 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 2,372

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: 6/30/2018 Fiscal Year: 6/30/2018

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

STATE OF ILLINOIS

Facility Name & ID Number Rosewood Care Center Of Moline # 0049304 Report Period Beginning: 07/01/17 Ending: 06/30/18

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		1,682	415,264	416,946		416,946		416,946			1
2	Food Purchase		194,749		194,749		194,749	(6,540)	188,209			2
3	Housekeeping		14,684	154,381	169,065		169,065		169,065			3
4	Laundry			102,921	102,921		102,921		102,921			4
5	Heat and Other Utilities			160,056	160,056		160,056	(11,568)	148,488			5
6	Maintenance	34,341	6,826	302,181	343,348		343,348	(93,838)	249,510			6
7	Other (specify):*							3,030	3,030			7
8	**TOTAL General Services**	34,341	217,941	1,134,803	1,387,085		1,387,085	(108,916)	1,278,169			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,439,669	234,959	1,131,547	2,806,175		2,806,175	31,846	2,838,021			10
10a	Therapy	67,810	2,535		70,345		70,345		70,345			10a
11	Activities	60,667	3,556	2,500	66,723		66,723		66,723			11
12	Social Services	54,605		2,551	57,156		57,156		57,156			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							3,239	3,239			15
16	**TOTAL Health Care and Programs**	1,622,751	241,050	1,136,598	3,000,399		3,000,399	35,085	3,035,484			16
	C. General Administration											
17	Administrative	83,893		292,764	376,657		376,657	(256,298)	120,359			17
18	Directors Fees											18
19	Professional Services			82,235	82,235		82,235	(10,988)	71,247			19
20	Dues, Fees, Subscriptions & Promotions			27,045	27,045		27,045	199	27,244			20
21	Clerical & General Office Expenses	74,593	17,373	366,225	458,191		458,191	(225,054)	233,137			21
22	Employee Benefits & Payroll Taxes			259,710	259,710		259,710		259,710			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,211	2,211		2,211	357	2,568			24
25	Other Admin. Staff Transportation			4,271	4,271		4,271	12,097	16,368			25
26	Insurance-Prop.Liab.Malpractice			96,112	96,112		96,112	12,544	108,656			26
27	Other (specify):*							26,497	26,497			27
28	**TOTAL General Administration**	158,486	17,373	1,130,573	1,306,432		1,306,432	(440,646)	865,786			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,815,578	476,364	3,401,974	5,693,916		5,693,916	(514,476)	5,179,440			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: 07/01/17 Ending: 06/30/18

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			9,455	9,455		9,455	134,045	143,500			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			95,256	95,256		95,256	450,706	545,962			32
33	Real Estate Taxes							116,868	116,868			33
34	Rent-Facility & Grounds			1,125,150	1,125,150		1,125,150	(1,107,397)	17,753			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			19,151	19,151		19,151	29,797	48,948			36
37	**TOTAL Ownership**			1,249,012	1,249,012		1,249,012	(375,981)	873,031			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		226,906	516,839	743,745		743,745		743,745			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			277,213	277,213		277,213		277,213			42
43	Other (specify):*	60,225		3,933	64,158		64,158	(64,158)	0			43
44	**TOTAL Special Cost Centers**	60,225	226,906	797,985	1,085,116		1,085,116	(64,158)	1,020,958			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,875,803	703,270	5,448,971	8,028,044		8,028,044	(954,615)	7,073,429			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: 07/01/17 Ending: 06/30/18

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	(1,149)	02		4
5	Telephone, TV & Radio in Resident Rooms	(11,970)	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	12,881	30		9
10	Interest and Other Investment Income	(8,469)	32		10
11	Discounts, Allowances, Rebates & Refunds	(4,509)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(464)	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	(7,927)	21		18
19	Entertainment	(25)	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	(302,392)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(206,974)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (530,998)		$	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)	(423,617)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (423,617)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (954,615)		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

Rosewood Care Center Of Moline

ID# 0049304

Report Period Beginning: 07/01/17

Ending: 06/30/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Salary	$ (60,225)	43	1
2	Marketing	(3,933)	43	2
3	Bank Charges	(3,032)	21	3
4	Vending Income	(418)	02	4
5	Vendor Late Charges	(19,465)	21	5
6	Midcap Line of Credit Fees	(19,151)	36	6
7	Miscellaneous Other Income	(980)	21	7
8	Building Co. - Audit Fees	(7,290)	19	8
9	Building Co. - Bank Charges	(13,338)	21	9
10	Building Co. - Amortization Loan Fee	(4,928)	36	10
11	Capitalized R&M	(68,419)	06	11
12	PAC Dues	(2,835)	20	12
13	Non-Allowable Legal Fees	(2,961)	19	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(206,974)		49

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Rosewood Care Center Of Moline

ID# **0049304**

Report Period Beginning: **07/01/17**

Ending: **06/30/18**

	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: 07/01/17 Ending: 06/30/18

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(6,540)											(6,540)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(11,970)					241	161					(11,568)	5
6	Maintenance	(68,419)					69	(25,488)					(93,838)	6
7	Other (specify):*							3,030					3,030	7
8	**TOTAL General Services**	(86,929)					310	(22,297)					(108,916)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				31,846								31,846	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				3,239								3,239	15
16	**TOTAL Health Care and Programs**				35,085								35,085	16
	C. General Administration													
17	Administrative			13,458	(114,992)		(154,764)						(256,298)	17
18	Directors Fees													18
19	Professional Services	(10,251)	7,290	18,581	343	(26,952)							(10,988)	19
20	Fees, Subscriptions & Promotions	(2,835)			8	195	2,814	16					199	20
21	Clerical & General Office Expenses	(347,160)	18,738		593	19,399	83,046	329					(225,054)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar				60	145	152						357	24
25	Other Admin. Staff Transportation				3,865	609	5,959	1,664					12,097	25
26	Insurance-Prop.Liab.Malpractice		7,350				4,549	645					12,544	26
27	Other (specify):*				2,082	2,043	22,372						26,497	27
28	**TOTAL General Administration**	(360,245)	33,378	32,038	(108,040)	(4,559)	(35,873)	2,654					(440,646)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(447,173)	33,378	32,038	(72,954)	(4,559)	(35,563)	(19,643)					(514,476)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Center Of Moline # 0049304 Report Period Beginning: 07/01/17 Ending: 06/30/18

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	12,881	112,531				8,477	155					134,045	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(8,469)	444,980	(1,087)			15,283						450,706	32
33	Real Estate Taxes		116,868										116,868	33
34	Rent-Facility & Grounds		(1,123,202)				15,805						(1,107,397)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*	(24,079)	53,876										29,797	36
37	**TOTAL Ownership**	(19,667)	(394,947)	(1,087)			39,565	155					(375,981)	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):*	(64,158)											(64,158)	43
44	**TOTAL Special Cost Centers**	(64,158)											(64,158)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(530,998)	(361,569)	30,951	(72,954)	(4,559)	4,001	(19,487)					(954,615)	45

Facility Name & ID Number Rosewood Care Center Of Moline # 0049304 Report Period Beginning: 07/01/17 Ending: 06/30/18

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 Pg. 6-Supplemental		See Pg. 6-Supplemental		See Pg. 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	19	Audit Fees - HB&Co		Moline Real Estate, LLC		7,290	7,290	2
3	V	21	Bank Charges		Moline Real Estate, LLC		13,338	13,338	3
4	V	32	Interest Expense - HUD Mortgage		Moline Real Estate, LLC		444,980	444,980	4
5	V	36	Interest Expense - HUD MIP		Moline Real Estate, LLC		48,948	48,948	5
6	V	33	Real Estate Tax		Moline Real Estate, LLC		116,868	116,868	6
7	V	30	Depreciation		Moline Real Estate, LLC		112,531	112,531	7
8	V	36	Amortization Loan Fee		Moline Real Estate, LLC		4,928	4,928	8
9	V	21	Base Admin Fee		Moline Real Estate, LLC		5,400	5,400	9
10	V	26	Insurance Expense - Property		Moline Real Estate, LLC		7,350	7,350	10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,123,202			$ 761,633	$ * (361,569)	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: 07/01/17 Ending: 06/30/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	CONSULTING FEES	$	BRAVO HOLDING COMPANY	100.00%	$ 13,458	$ 13,458	15
16	V	19	PROFESSIONAL FEES		BRAVO HOLDING COMPANY	100.00%	18,581	18,581	16
17	V	32	INTEREST		BRAVO HOLDING COMPANY	100.00%	(1,087)	(1,087)	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			$			$ 30,951	$ * 30,951	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: 07/01/17 Ending: 06/30/18

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%	$ 31,846	$ 31,846	15
16	V	15	CORPORATE RN SALARIES BENEFITS		BRAVO NURSING HOME SERVICES, INC.	100.00%	3,239	3,239	16
17	V	17	ADMINISTRATIVE SALARIES		BRAVO NURSING HOME SERVICES, INC.	100.00%	23,008	23,008	17
18	V	19	PROFESSIONAL FEES		BRAVO NURSING HOME SERVICES, INC.	100.00%	343	343	18
19	V	20	DUES & SUBSCRIPTIONS		BRAVO NURSING HOME SERVICES, INC.	100.00%	8	8	19
20	V	21	OFFICE EXPENSES		BRAVO NURSING HOME SERVICES, INC.	100.00%	593	593	20
21	V	24	SEMINAR & LODGING EXPENSE		BRAVO NURSING HOME SERVICES, INC.	100.00%	60	60	21
22	V	25	AUTO EXPENSE		BRAVO NURSING HOME SERVICES, INC.	100.00%	3,865	3,865	22
23	V	27	ADMINISTRATIVE & OFFICE BENEFITS		BRAVO NURSING HOME SERVICES, INC.	100.00%	2,082	2,082	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			$ 65,046	$ * (72,954)	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: 07/01/17 Ending: 06/30/18

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%	$ 868	$ 868	15
16	V	20	LICENSES		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	195	195	16
17	V	21	LEGAL SALARIES		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	18,499	18,499	17
18	V	21	OFFICE EXPENSE		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	901	901	18
19	V	24	SEMINAR		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	145	145	19
20	V	25	AUTO / TRAVEL EXPENSE		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	609	609	20
21	V	27	EMPLOYEE BENEFITS		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	2,043	2,043	21
22	V								22
23	V	19	PROFESSIONAL FEES	27,820	CLAIMS ADMINISTRATION SERVICES, LLC	100.00%		(27,820)	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			$ 27,820			$ 23,261	$ * (4,559)	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: 07/01/17 Ending: 06/30/18

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%	$ 241	$ 241	15
16	V	6	MAINTENANCE EXPENSE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	69	69	16
17	V	20	DUES, SUBSCRIPTIONS, LICENSES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	2,814	2,814	17
18	V	21	OFFICE SALARIES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	70,783	70,783	18
19	V	21	OFFICE EXPENSES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	17,663	17,663	19
20	V	24	SEMINAR		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	152	152	20
21	V	25	TRAVEL EXPENSE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	5,959	5,959	21
22	V	26	INSURANCE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	4,549	4,549	22
23	V	27	EMPLOYEE BENEFITS		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	22,372	22,372	23
24	V	30	DEPRECIATION		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	8,477	8,477	24
25	V	32	INTEREST		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	15,283	15,283	25
26	V	34	BUILDING RENT		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	15,805	15,805	26
27	V								27
28	V								28
29	V	17	ADMINISTRATIVE FEE	154,764	MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%		(154,764)	29
30	V	21	ADMINISTRATIVE FEE (BLDG CO)	5,400	MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%		(5,400)	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			$ 160,164			$ 164,165	$ * 4,001	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: 07/01/17 Ending: 06/30/18

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%	$ 161	$ 161	15
16	V	6	MAINTENANCE SALARY		SENIOR LIVING SERVICES, INC.	100.00%	21,641	21,641	16
17	V	6	MAINTENANCE EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	2,273	2,273	17
18	V	7	MAINTENANCE BENEFITS		SENIOR LIVING SERVICES, INC.	100.00%	3,030	3,030	18
19	V	20	LICENSES		SENIOR LIVING SERVICES, INC.	100.00%	16	16	19
20	V	21	OFFICE EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	329	329	20
21	V	25	AUTO / TRAVEL EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	1,664	1,664	21
22	V	26	INSURANCE		SENIOR LIVING SERVICES, INC.	100.00%	645	645	22
23	V	30	DEPRECIATION		SENIOR LIVING SERVICES, INC.	100.00%	155	155	23
24	V								24
25	V	6	MAINTENANCE SERVICES	49,477	SENIOR LIVING SERVICES, INC.	100.00%	75	(49,402)	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			$ 49,477			$ 29,990	$ * (19,487)	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: 07/01/17 Ending: 06/30/18

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: 07/01/17 Ending: 06/30/18

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: 07/01/17 Ending: 06/30/18

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: 07/01/17 Ending: 06/30/18

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: 07/01/17 Ending: 06/30/18

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, In	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, In	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: 07/01/17 Ending: 06/30/18

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: 07/01/17 Ending: 06/30/18

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: 07/01/17 Ending: 06/30/18

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: 07/01/17 Ending: 06/30/18

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	17	CONSULTING FEES	PATIENT DAYS	445,689	14	$ 200,000	$	29,990	$ 13,458	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	445,689	14	276,131		29,990	18,581	2
3	32	INTEREST	PATIENT DAYS	445,689	14	(16,156)		29,990	(1,087)	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					$ 459,975	$		$ 30,951	25

Facility Name & ID Number Rosewood Care Center Of Moline # 0049304 Report Period Beginning: 07/01/17 Ending: 06/30/18

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	445,689	14	$ 473,276	$ 473,276	29,990	$ 31,846	1
2	15	CORPORATE RN SALARIES BE	PAT. DAYS	445,689	14	48,136		29,990	3,239	2
3	17	ADMINISTRATIVE SALARIES	PAT. DAYS	445,689	14	341,934	341,934	29,990	23,008	3
4	19	PROFESSIONAL FEES	PAT. DAYS	445,689	14	5,100		29,990	343	4
5	20	DUES & SUBSCRIPTIONS	PAT. DAYS	445,689	14	121		29,990	8	5
6	21	OFFICE EXPENSES	PAT. DAYS	445,689	14	8,815		29,990	593	6
7	24	SEMINAR & LODGING EXPENS	PAT. DAYS	445,689	14	888		29,990	60	7
8	25	AUTO EXPENSE	PAT. DAYS	445,689	14	57,444		29,990	3,865	8
9	27	ADMINISTRATIVE & OFFICE B	PAT. DAYS	445,689	14	30,948		29,990	2,082	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					$ 966,663	$ 815,210		$ 65,046	25

Facility Name & ID Number Rosewood Care Center Of Moline # 0049304 Report Period Beginning: 07/01/17 Ending: 06/30/18

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	307,124	14	$ 9,587	$	27,820	$ 868	1
2	20	LICENSES	ACTUAL FEES	307,124	14	2,155		27,820	195	2
3	21	LEGAL SALARIES	ACTUAL FEES	307,124	14	204,221	204,221	27,820	18,499	3
4	21	OFFICE EXPENSE	ACTUAL FEES	307,124	14	9,942		27,820	901	4
5	24	SEMINAR	ACTUAL FEES	307,124	14	1,603		27,820	145	5
6	25	AUTO / TRAVEL EXPENSE	ACTUAL FEES	307,124	14	6,726		27,820	609	6
7	27	EMPLOYEE BENEFITS	ACTUAL FEES	307,124	14	22,559		27,820	2,043	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					$ 256,792	$ 204,221		$ 23,261	25

Facility Name & ID Number Rosewood Care Center Of Moline # 0049304 Report Period Beginning: 07/01/17 Ending: 06/30/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: MIDWEST ADMINISTRATIVE SERVICES, INC
Street Address: 11701 BORMAN DRIVE, SUITE 315
City / State / Zip Code: ST. LOUIS, MO 63146
Phone Number: (314) 994-9070
Fax Number: (314) 994-9912

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PAT. DAYS	445,689	14	$ 3,576	$	29,990	$ 241	1
2	6	MAINTENANCE EXPENSE	PAT. DAYS	445,689	14	1,030		29,990	69	2
3	20	DUES, SUBSCRIPTIONS, LICEN	PAT. DAYS	445,689	14	41,819		29,990	2,814	3
4	21	OFFICE SALARIES	PAT. DAYS	445,689	14	1,051,919	1,051,919	29,990	70,783	4
5	21	OFFICE EXPENSES	PAT. DAYS	445,689	14	262,500		29,990	17,663	5
6	24	SEMINAR	PAT. DAYS	445,689	14	2,257		29,990	152	6
7	25	TRAVEL EXPENSE	PAT. DAYS	445,689	14	88,555		29,990	5,959	7
8	26	INSURANCE	PAT. DAYS	445,689	14	67,605		29,990	4,549	8
9	27	EMPLOYEE BENEFITS	PAT. DAYS	445,689	14	332,469		29,990	22,372	9
10	30	DEPRECIATION	PAT. DAYS	445,689	14	125,986		29,990	8,477	10
11	32	INTEREST	PAT. DAYS	445,689	14	227,119		29,990	15,283	11
12	34	BUILDING RENT	PAT. DAYS	445,689	14	234,875		29,990	15,805	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,439,709	$ 1,051,919		$ 164,165	25

Facility Name & ID Number Rosewood Care Center Of Moline # 0049304 Report Period Beginning: 07/01/17 Ending: 06/30/18

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	1,015,133	14	$ 3,306	$	49,477	$ 161	1
2	6	MAINTENANCE SALARY	ACTUAL FEES	1,015,133	14	444,019	444,019	49,477	21,641	2
3	6	MAINTENANCE EXPENSE	ACTUAL FEES	1,015,133	14	46,631		49,477	2,273	3
4	7	MAINTENANCE BENEFITS	ACTUAL FEES	1,015,133	14	62,159		49,477	3,030	4
5	20	LICENSES	ACTUAL FEES	1,015,133	14	332		49,477	16	5
6	21	OFFICE EXPENSE	ACTUAL FEES	1,015,133	14	6,751		49,477	329	6
7	25	AUTO / TRAVEL EXPENSE	ACTUAL FEES	1,015,133	14	34,139		49,477	1,664	7
8	26	INSURANCE	ACTUAL FEES	1,015,133	14	13,240		49,477	645	8
9	30	DEPRECIATION	ACTUAL FEES	1,015,133	14	3,189		49,477	155	9
10										10
11	6	MAINTENANCE SERVICES	DIRECT ALLOCATION		14	4,891			75	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					$ 618,657	$ 444,019		$ 29,990	25

Facility Name & ID Number Rosewood Care Center Of Moline # 0049304 Report Period Beginning: 07/01/17 Ending: 06/30/18

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: 07/01/17 Ending: 06/30/18

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: 07/01/17 Ending: 06/30/18

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: 07/01/17 Ending: 06/30/18

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: 07/01/17 Ending: 06/30/18

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Berkadia		X	Mortgage	$87,636.51	11/1/05	$ 6,524,600	$ 11,615,408	12/1/40	0.0480	$ 444,980	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MidCap		X	Line of Credit							95,256	6
7	Bravo Holding		X	Note Payable				210,446				7
8												8
9	TOTAL Facility Related				$87,636.51		$ 6,524,600	$ 11,825,854			$ 540,236	9
	B. Non-Facility Related*											
10	Interest Income		X								(5,050)	10
11	Interest Income - Bravo Hldg		X								(3,419)	11
12	Allocated from Bravo Holding Compan		X								(1,087)	12
13	See Supplemental Schedule										15,283	13
14	TOTAL Non-Facility Related						$	$			$ 5,727	14
15	TOTALS (line 9+line14)						$ 6,524,600	$ 11,825,854			$ 545,963	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 48,948 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: 07/01/17 Ending: 06/30/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 156,190	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.)		$ 131,230	2
3. Under or (over) accrual (line 2 minus line 1).		$ (24,960)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 241,082	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.		$ 216,122	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	121,940	8
	2014	121,543	9
	2015	124,993	10
	2016	127,903	11
	2017	131,230	12

Accrual based on prior year tax bill.

RE Taxes on line 2 are the second installment of the 2016 tax bill and the first installment of the 2017 tax bill.

The variance of $99,254 between line 7 above and line 33 on page 4, is the amount of the first installment of the 2017 bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 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

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 2017 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 2017.

	(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	$ 21,914.08	$ 21,914.08
2.	07-649-95-00	Long Term Care Property	$ 109,315.84	$ 109,315.84
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 131,229.92	$ 131,229.92

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 2017 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 2017 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2017.

Please complete the Real Estate Tax Statement below and include it in the 2018 cost report along with a copy of your 2017 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.

2017 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

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 2017 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 2017.

	(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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 07/01/17 Ending: 06/30/18

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: 07/01/17 Ending: 06/30/18

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	$ 112,531	40	$ 78,060	$ (34,471)	$ 2,144,893	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: 07/01/17 Ending: 06/30/18

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)		681,402			24,677	24,677	503,092	67
68	Related Party Allocations (Pages 12H & 12I)		191	38		38		76	68
69	Financial Statement Depreciation			9,455			(9,455)		69
70	TOTAL (lines 4 thru 69)		$ 3,804,003	$ 122,024		$ 102,775	$ (19,249)	$ 2,648,061	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: 07/01/17 Ending: 06/30/18

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		$ 3,804,003	$ 122,024		$ 102,775	$ (19,249)	$ 2,648,061	1
2	Rewire Therapy Kitchen, Power Feed For Irrigation Pump	2016	3,472		20	174	174	521	2
3	Wiring-Kitch/Leak Repair - Dining Room/Changed Blower Belt	2016	4,954		20	198	198	396	3
4	Pipe Leak Repair	2016	2,614		20	105	105	210	4
5	Dry System Leak Repair	2017	5,728		20	229	229	458	5
6	Air Compressor Repair	2017	3,680		20	147	147	294	6
7	Remove Old Pendants And Install New Replacements	2017	3,420		20	137	137	274	7
8	Replace Evaportor Coil And Expansion Valve For Hp 22 Kitchen	2017	4,836		20	242	242	242	8
9	Replace In-Line Check At Riser And Repair Leak In Piping	2017	4,021		20	201	201	201	9
10	Site Concrete Repairs	2017	2,922		20	146	146	146	10
11	Sprinkler Leak In The 300/400 Wing	2017	2,588		20	129	129	129	11
12	Leak In Sprinkler Pipe Above 100/200 Nurse Station	2017	3,418		20	171	171	171	12
13	Replacement Tube Bundle For Cooling Tower	2017	16,795		20	840	840	840	13
14	Install Owner-Furnished Tube Bundle In Cooling Tower	2017	10,300		20	515	515	515	14
15	Door Repairs	2018	4,887		20	244	244	244	15
16	Repair Leaks In Loop Piping In Mechanical Room	2018	18,652		20	933	933	933	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)		$ 3,896,290	$ 122,024		$ 107,186	$ (14,839)	$ 2,653,636	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: 07/01/17 Ending: 06/30/18

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		$ 3,896,290	$ 122,024		$ 107,186	$ (14,839)	$ 2,653,636	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)		$ 3,896,290	$ 122,024		$ 107,186	$ (14,839)	$ 2,653,636	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: 07/01/17 Ending: 06/30/18

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		$ 3,896,290	$ 122,024		$ 107,186	$ (14,839)	$ 2,653,636	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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19									19
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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)		$ 3,896,290	$ 122,024		$ 107,186	$ (14,839)	$ 2,653,636	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: 07/01/17 Ending: 06/30/18

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		$ 3,896,290	$ 122,024		$ 107,186	$ (14,839)	$ 2,653,636	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,896,290	$ 122,024		$ 107,186	$ (14,839)	$ 2,653,636	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: 07/01/17 Ending: 06/30/18

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	10,222	17
18	Water Meter & Back	1993	1,803		25	72	72	1,791	18
19	Parking Lot Addition	2000	11,485		25	459	459	8,114	19
20	Seal & Restripe Parking Lot	2003	4,530		25	181	181	2,687	20
21	Shingle Roof Replacement	2005	24,958		40	624	624	8,424	21
22	Parking Lot Improvements	2005	16,350		40	409	409	5,281	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	1,488	26
27	Telephone System	2008	20,911		10	1,743	1,743	20,911	27
28	Doors	2009	5,097		10	510	510	4,716	28
29	Grease Trap	2009	4,875		10	488	488	4,552	29
30	New Windows	2009	2,625		10	263	263	2,297	30
31	Replace Sidewalks	2009	10,980		25	439	439	3,915	31
32	Carpet - Office, Resident Lounge, Dining Room, Waiting Areas	2010	11,593		10	1,159	1,159	9,853	32
33	Doors - Rooms 201, 405, 534, 535	2010	4,402		10	440	440	3,557	33
34	TOTAL (lines 1 thru 33)		$ 470,683	$		$ 7,346	$ 7,346	$ 424,910	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: 07/01/17 Ending: 06/30/18

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	$		$ 7,346	$ 7,346	$ 424,910	1
2	Countertops in Beverage Room & Therapy Room	2010	2,570		10	257	257	2,077	2
3	Sealcoat Parking Lot	2010	4,855		25	194	194	1,569	3
4	HVAC	2010	3,035		10	304	304	2,327	4
5	Sinks	2011	7,968		10	797	797	4,616	5
6	Crack, Repair & Control Joint Caulking Entire Building	2011	24,950		40	624	624	4,263	6
7	Sprinkler System	2011	8,427		10	843	843	5,635	7
8	Doors - Exterior	2011	29,823		10	2,982	2,982	20,129	8
9	HVAC	2012	28,173		10	2,817	2,817	18,311	9
10	Doors - Exterior	2012	3,096		10	310	310	1,937	10
11	Nurse Call System	2012	3,256		10	326	326	2,037	11
12	Hot Water Boiler	2012	9,404		40	235	235	1,397	12
13	Sealcoat Parking Lot	2012	6,678		25	267	267	1,558	13
14	HVAC Improvements	2014	5,301		10	530	530	2,252	14
15	Sealcoating	2014	5,595		25	224	224	840	15
16	Cooling Tower	2015	13,064		10	1,306	1,306	3,918	16
17	Sprinkler Pendants	2017	47,325		10	4,733	4,733	4,733	17
18	Exchange Boiler	2017	3,101		10	310	310	310	18
19	Cabinets	2017	4,098		15	273	273	273	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)		$ 681,402	$		$ 24,677	$	$ 503,092	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: 07/01/17 Ending: 06/30/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Senior Living Services	2017	191	38	20	38		76	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)		$ 191	$ 38		$ 38	$	$ 76	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: 07/01/17 Ending: 06/30/18

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		$ 191	$ 38		$ 38	$	$ 76	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
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 191	$ 38		$ 38	$	$ 76	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: 07/01/17 Ending: 06/30/18

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	$ 339,581	$ 2,214	$ 29,933	$ 27,719	10	$ 301,694	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	18,003	161	161		10	18,003	73
74								74
75	TOTALS	$ 357,584	$ 2,375	$ 30,094	$ 27,719		$ 319,697	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from MAS	2016	$ 45,155	$ 6,102	$ 6,102	$ 0	5	$ 43,271	76
77		Allocated from Senior Living Serv	2016	7,295	117	117	0	5	7,295	77
78										78
79										79
80	TOTALS			$ 52,450	$ 6,219	$ 6,220	$ 1		$ 50,566	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)	$	5,357,439	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	130,618	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	143,499	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	12,881	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	3,023,899	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: 07/01/17 Ending: 06/30/18

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Off-Site Storage				1,948			5
6	Allocated from MAS				15,805			6
7	TOTAL				$ 17,753 **			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.	/2019	$
13.	/2020	$
14.	/2021	$

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: 07/01/17 Ending: 06/30/18

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: 07/01/17 Ending: 06/30/18

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	$		$ 177,244	$		$ 177,244	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			71,063			71,063	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			252,376			252,376	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				215,565		215,565	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					16,156	11,341		27,497	13
14	TOTAL			$		$ 516,839	$ 226,906		$ 743,745	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: 07/01/17 Ending: 06/30/18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/18 (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	$ 500	$ 500	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,491,226	2,491,226	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	63,446	68,024	6
7	Other Prepaid Expenses		216,100	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	5,419	5,419	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,560,591	$ 2,781,269	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		255,571	15
16	Equipment, at Historical Cost	58,097	678,332	16
17	Accumulated Depreciation (book methods)	(57,809)	(2,942,179)	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): See Attached Schedule		10,000	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 288	$ 2,165,397	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,560,879	$ 4,946,666	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,168,471	$ 3,308,261	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	210,446	210,446	29
30	Accrued Salaries Payable	130,330	130,330	30
31	Accrued Taxes Payable (excluding real estate taxes)	202,889	202,889	31
32	Accrued Real Estate Taxes(Sch.IX-B)		241,082	32
33	Accrued Interest Payable		1,610,724	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	9,067	25,197	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	3,819,969	422,401	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 7,541,172	$ 6,151,330	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)**	$ 7,541,172	$ 17,766,738	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (4,980,293)	$ (12,820,072)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,560,879	$ 4,946,666	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,071,089)	1
2	Restatements (describe):		2
3	**Equity Adjustment**	(5,769)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,076,858)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,903,435)	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)**	$ (1,903,435)	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)**	$ (4,980,293)	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	$ 5,971,064	1
2	Discounts and Allowances for all Levels	(1,499,889)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,471,175	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,304,431	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,304,431	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	900	13
14	Non-Patient Meals	1,149	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	277,394	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,325	19
20	Radiology and X-Ray	3,135	20
21	Other Medical Services	35,574	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 325,477	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,469	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,469	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	15,057	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 15,057	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,124,609	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,387,085	31
32	Health Care	3,000,399	32
33	General Administration	1,306,432	33
	B. Capital Expense		
34	Ownership	1,249,012	34
	C. Ancillary Expense		
35	Special Cost Centers	807,903	35
36	Provider Participation Fee	277,213	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,028,044	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,903,435)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,903,435)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,479,445	44
45	Private Pay - Net Inpatient Revenue	1,385,084	45
46	Medicare - Net Inpatient Revenue	296,749	46
47	Other-(specify) Insurance/Managed Care	309,897	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,471,175	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	1,801	1,874	$ 73,698	$ 39.33	1
2	Assistant Director of Nursing	1,838	2,012	65,689	32.65	2
3	Registered Nurses	11,166	11,990	303,327	25.30	3
4	Licensed Practical Nurses	15,467	16,708	371,797	22.25	4
5	CNAs & Orderlies	46,159	49,023	584,062	11.91	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,506	3,930	67,810	17.25	8
9	Activity Director	2,240	2,382	31,958	13.42	9
10	Activity Assistants	3,146	3,311	28,709	8.67	10
11	Social Service Workers	3,767	3,970	54,605	13.75	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	2,079	2,224	34,341	15.44	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,929	2,044	83,893	41.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,339	6,865	74,593	10.87	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	3,579	3,859	41,096	10.65	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	2,334	2,547	60,224	23.65	33
34	TOTAL (lines 1 - 33)	105,350	112,739	$ 1,875,802 *	$ 16.64	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				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,848	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	2,500	11-03	44
45	Social Service Consultant	Monthly	2,551	12-03	45
46	Other(specify) Outsourced Dietary	Monthly	415,264	01-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 428,163		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,744	$ 109,749	10-03	50
51	Licensed Practical Nurses	6,867	274,697	10-03	51
52	Certified Nurse Assistants/Aides	28,433	739,253	10-03	52
53	TOTAL (lines 50 - 52)	38,044	$ 1,123,699		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Trudy Whittington	Administrator		$ 83,893
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 83,893

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	118,764
TOTAL (agree to Schedule V, line 17, col. 3)	$ 292,764
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 9,219
Ability Network	Healthcare Technology	3,827
Resolute Healthcare Solutions	Claims Management	1,396
Claims Administrative Services	Related Party Legal	27,820
Infinite Solutions	IT Support	21,888
See Attached	Legal	18,085
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 82,234

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 54,658
Unemployment Compensation Insurance	35,553
FICA Taxes	130,259
Employee Health Insurance	30,742
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals & Vaccinations	1,621
Dental Insurance	1,437
Employee Relations	2,484
401K Expense	1,638
Employee Drug Tests	1,320
TOTAL (agree to Schedule V, line 22, col.8)	$ 259,711

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	$ 1,990
Advertising: Employee Recruitment	14,229
Health Care Worker Background Check	1,932
(Indicate # of checks performed 193)	
Patient Background Checks	
Dues & Subscriptions	6,059
Allocated from Bravo Nursing Home Services	8
Allocated from CAS	195
Allocated from MAS	2,814
See Supplemental Schedule	16
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,243

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,211
Allocated from Bravo Nursing Home Services	60
Allocated from CAS	145
See Supplemental Schedule	152
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,568

* 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: $8,894**

(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. $ **61,128** 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. $ **277,213**
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. $ **1,149**

(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? **100% Ln 14**
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