

Facility Name & ID Number Rosewood Care Ctr of Moline

0049304 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF		3,798	5,697	9,495	8
9	SNF/PED					9
10	ICF	15,588	4,335		19,923	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,588	8,133	5,697	29,418	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.16%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 58 and days of care provided 3,806

Medicare Intermediary Novitas Solutions, Inc.

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

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

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	239,661	21,163	8,349	269,173		269,173	1,440	270,613		1
2	Food Purchase		190,242		190,242		190,242	(9,504)	180,738		2
3	Housekeeping	138,660	29,075		167,735		167,735		167,735		3
4	Laundry	37,498	11,625		49,123		49,123		49,123		4
5	Heat and Other Utilities			138,080	138,080		138,080	188	138,268		5
6	Maintenance	29,479	8,946	180,324	218,749		218,749	(23,259)	195,490		6
7	Other (specify):* Allocated HO Benefits							3,848	3,848		7
8	TOTAL General Services	445,298	261,051	326,753	1,033,102		1,033,102	(27,287)	1,005,815		8
	B. Health Care and Programs										
9	Medical Director			11,250	11,250		11,250		11,250		9
10	Nursing and Medical Records	1,645,295	149,927	13,449	1,808,671		1,808,671	39,825	1,848,496		10
10a	Therapy		1,722	617,141	618,863		618,863		618,863		10a
11	Activities	49,585	3,841	2,300	55,726		55,726		55,726		11
12	Social Services	41,432		2,350	43,782		43,782		43,782		12
13	CNA Training										13
14	Program Transportation			100	100		100		100		14
15	Other (specify):* Allocated HO Benefits							3,358	3,358		15
16	TOTAL Health Care and Programs	1,736,312	155,490	646,590	2,538,392		2,538,392	43,183	2,581,575		16
	C. General Administration										
17	Administrative	87,570		229,432	317,002		317,002	(215,419)	101,583		17
18	Directors Fees										18
19	Professional Services			104,783	104,783		104,783	80,701	185,484		19
20	Dues, Fees, Subscriptions & Promotions			27,641	27,641		27,641	(1,157)	26,484		20
21	Clerical & General Office Expenses	85,894	13,502	36,533	135,929		135,929	134,003	269,932		21
22	Employee Benefits & Payroll Taxes			359,944	359,944		359,944		359,944		22
23	Inservice Training & Education			220	220		220		220		23
24	Travel and Seminar			278	278		278	5,404	5,682		24
25	Other Admin. Staff Transportation			4,764	4,764		4,764	1,966	6,730		25
26	Insurance-Prop.Liab.Malpractice			44,464	44,464		44,464	37,668	82,132		26
27	Other (specify):* Allocated HO Benefits							12,512	12,512		27
28	TOTAL General Administration	173,464	13,502	808,059	995,025		995,025	55,678	1,050,703		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,355,074	430,043	1,781,402	4,566,519		4,566,519	71,574	4,638,093		29

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

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

Facility Name & ID Number

Rosewood Care Ctr of Moline

#0049304

Report Period Beginning:

07/01/2013

Ending:

06/30/2014

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			11,694	11,694		11,694	69,514	81,208			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			111,367	111,367		111,367	178,587	289,954			32
33	Real Estate Taxes			61,871	61,871		61,871	31,121	92,992			33
34	Rent-Facility & Grounds			1,086,018	1,086,018		1,086,018	(547,154)	538,864			34
35	Rent-Equipment & Vehicles			25,528	25,528		25,528	8,586	34,114			35
36	Other (specify):*											36
37	TOTAL Ownership			1,296,478	1,296,478		1,296,478	(259,346)	1,037,132			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		202,482		202,482		202,482		202,482			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			214,737	214,737		214,737		214,737			42
43	Other (specify):* See Schedule 4A	81,509		300,294	381,803		381,803	(367,788)	14,015			43
44	TOTAL Special Cost Centers	81,509	202,482	515,031	799,022		799,022	(367,788)	431,234			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,436,583	632,525	3,592,911	6,662,019		6,662,019	(555,560)	6,106,459			45

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

Rosewood Care Ctr of Moline

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

Schedule 4A

V. Cost Center Expenses

		Cost Per General Ledger				Reclass- ification	Reclassified Total	Adjust- ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					5	6
		1	2	3	4						
	Ancillary Expense										
	E. Special Cost Centers										
43	Other (specify):*				0		0		0		
	Laboratory Expense			10,525	10,525		10,525		10,525		
	Radiology Expenses			3,490	3,490		3,490		3,490		
	Non-Allowable Expenses	81,509		286,279	367,788		367,788	(367,788)	0		
					0		0		0		
					0		0		0		
	TOTAL Other Special Cost Centers	81,509	0	300,294	381,803	0	381,803	(367,788)	14,015		

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(8,304)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,941)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(16,168)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,225)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(2,637)	20		17
18	Fines and Penalties				18
19	Entertainment	(242)	43		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,739)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(273,147)	43		24
25	Fund Raising, Advertising and Promotional	(5,269)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(296)	43		28
29	Other-Attach Schedule See Page 5A	(86,522)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (406,490)		\$	30

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	2	
		Amount	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)	(149,070)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (149,070)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (555,560)		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Rosewood Care Ctr of Moline

ID# 0049304

Report Period Beginning: 07/01/2013

Ending: 06/30/2014

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Eliminate Marketing Salary	\$ (81,509)	43	1
2	Miscellaneous Income Offset	(89)	21	2
3	Disallow Resident Reimbursement	(384)	43	3
4	Disallow Marketing Mileage Reimbursement	(4,540)	25	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
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		(86,522)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Ctr of Moline# 0049304

Report Period Beginning:

07/01/2013

Ending:

06/30/2014

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	1,440	0	0	0	0	0	0	0	0	1,440	1
2	Food Purchase	(9,529)	0	25	0	0	0	0	0	0	0	0	(9,504)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	169	0	19	0	0	0	0	0	0	188	5
6	Maintenance	0	0	126	0	(23,385)	0	0	0	0	0	0	(23,259)	6
7	Other (specify):*	0	0	163	0	3,685	0	0	0	0	0	0	3,848	7
8	TOTAL General Services	(9,529)	0	1,923	0	(19,681)	0	0	0	0	0	0	(27,287)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	36,160	3,665	0	0	0	0	0	0	0	0	39,825	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	2,944	414	0	0	0	0	0	0	0	0	3,358	15
16	TOTAL Health Care and Programs	0	39,104	4,079	0	0	0	0	0	0	0	0	43,183	16
	C. General Administration													
17	Administrative	0	(125,762)	(93,257)	0	0	0	3,600	0	0	0	0	(215,419)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,739)	92	7,024	(5,781)	0	82,857	2,248	0	0	0	0	80,701	19
20	Fees, Subscriptions & Promotions	(2,637)	9	1,240	224	7	0	0	0	0	0	0	(1,157)	20
21	Clerical & General Office Expenses	(89)	41,298	79,534	10,879	566	375	1,440	0	0	0	0	134,003	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,461	2,400	90	1,399	54	0	0	0	0	0	5,404	24
25	Other Admin. Staff Transportation	(4,540)	2,208	1,036	218	3,044	0	0	0	0	0	0	1,966	25
26	Insurance-Prop.Liab.Malpractice	0	251	1,647	114	877	404	34,375	0	0	0	0	37,668	26
27	Other (specify):*	0	4,289	7,185	1,038	0	0	0	0	0	0	0	12,512	27
28	TOTAL General Administration	(13,005)	(76,154)	6,809	6,782	5,893	83,690	41,663	0	0	0	0	55,678	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(22,534)	(37,050)	12,811	6,782	(13,788)	83,690	41,663	0	0	0	0	71,574	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Ctr of Moline# 0049304

Report Period Beginning:

07/01/2013 Ending:06/30/2014

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

	Capital Expense	PAGES 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)	
	D. Ownership													
30	Depreciation	0	0	5,511	0	945	0	63,058	0	0	0	0	69,514	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(16,168)	0	396	57	0	(97,450)	291,752	0	0	0	0	178,587	32
33	Real Estate Taxes	0	0	0	0	0	0	31,121	0	0	0	0	31,121	33
34	Rent-Facility & Grounds	0	0	4,956	0	0	0	(552,110)	0	0	0	0	(547,154)	34
35	Rent-Equipment & Vehicles	0	7,568	1,018	0	0	0	0	0	0	0	0	8,586	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(16,168)	7,568	11,881	57	945	(97,450)	(166,179)	0	0	0	0	(259,346)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(367,788)	0	0	0	0	0	0	0	0	0	0	(367,788)	43
44	TOTAL Special Cost Centers	(367,788)	0	0	0	0	0	0	0	0	0	0	(367,788)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(406,490)	(29,482)	24,692	6,839	(12,843)	(13,760)	(124,516)	0	0	0	0	(555,560)	45

VII. RELATED PARTIES

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

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

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10 Nursing & Medical Records	\$	Bravo Nursing Home Services, Inc.	0.00%	\$ 36,160	\$ 36,160	1
2	V	15 Mgmt. Allocation of Benefits		Bravo Nursing Home Services, Inc.	0.00%	2,944	2,944	2
3	V	17 Mgmt Fee/Administrative	138,000	Bravo Nursing Home Services, Inc.	0.00%	12,238	(125,762)	3
4	V	19 Professional Services		Bravo Nursing Home Services, Inc.	0.00%	92	92	4
5	V	20 Dues, Fees, Subs & Promotions		Bravo Nursing Home Services, Inc.	0.00%	9	9	5
6	V	21 Clerical and General Office		Bravo Nursing Home Services, Inc.	0.00%	41,298	41,298	6
7	V	24 Travel and Seminar		Bravo Nursing Home Services, Inc.	0.00%	1,461	1,461	7
8	V	25 Other Admin. Staff Transport.		Bravo Nursing Home Services, Inc.	0.00%	2,208	2,208	8
9	V	26 Insurance-Prop./Liab./Malprac.		Bravo Nursing Home Services, Inc.	0.00%	251	251	9
10	V	27 Mgmt. Allocation of Benefits		Bravo Nursing Home Services, Inc.	0.00%	4,289	4,289	10
11	V	35 Rent-Equipment & Vehicles		Bravo Nursing Home Services, Inc.	0.00%	7,568	7,568	11
12	V							12
13	V							13
14	Total		\$ 138,000			\$ 108,518	\$ * (29,482)	14

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Midwest Administrative Services, Inc.	0.00%	\$ 1,440	\$	1,440	15
16	V	2 Food		Midwest Administrative Services, Inc.	0.00%	25		25	16
17	V	5 Utilities		Midwest Administrative Services, Inc.	0.00%	169		169	17
18	V	6 Maintenance		Midwest Administrative Services, Inc.	0.00%	126		126	18
19	V	7 Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	163		163	19
20	V	10 Nursing and Medical Records		Midwest Administrative Services, Inc.	0.00%	3,665		3,665	20
21	V	15 Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	414		414	21
22	V	17 Mgmt Fee/Administrative	95,032	Midwest Administrative Services, Inc.	0.00%	1,775		(93,257)	22
23	V	19 Professional Services		Midwest Administrative Services, Inc.	0.00%	7,024		7,024	23
24	V	20 Dues, Fees, Subs & Promotions		Midwest Administrative Services, Inc.	0.00%	1,240		1,240	24
25	V	21 Clerical and General Office		Midwest Administrative Services, Inc.	0.00%	79,534		79,534	25
26	V	24 Travel and Seminar		Midwest Administrative Services, Inc.	0.00%	2,400		2,400	26
27	V	25 Other Admin. Staff Transport.		Midwest Administrative Services, Inc.	0.00%	1,036		1,036	27
28	V	26 Insurance-Prop./Liab./Malprac.		Midwest Administrative Services, Inc.	0.00%	1,647		1,647	28
29	V	27 Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	7,185		7,185	29
30	V	30 Depreciation		Midwest Administrative Services, Inc.	0.00%	5,511		5,511	30
31	V	32 Interest		Midwest Administrative Services, Inc.	0.00%	396		396	31
32	V	34 Rent-Facility and Grounds		Midwest Administrative Services, Inc.	0.00%	4,956		4,956	32
33	V	35 Rent-Equipment & Vehicles		Midwest Administrative Services, Inc.	0.00%	1,018		1,018	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 95,032			\$ 119,724	\$ *	24,692	39

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19 Professional Services	\$ 6,310	Claims Administration Services, LLC	0.00%	\$ 529	\$ (5,781)	15
16	V	20 Dues, Fees, Subs & Promotions		Claims Administration Services, LLC	0.00%	224	224	16
17	V	21 Clerical and General Office		Claims Administration Services, LLC	0.00%	10,879	10,879	17
18	V	24 Travel and Seminar		Claims Administration Services, LLC	0.00%	90	90	18
19	V	25 Other Admin. Staff Transport.		Claims Administration Services, LLC	0.00%	218	218	19
20	V	26 Insurance-Prop./Liab./Malprac.		Claims Administration Services, LLC	0.00%	114	114	20
21	V	27 Mgmt. Allocation of Benefits		Claims Administration Services, LLC	0.00%	1,038	1,038	21
22	V	32 Interest		Claims Administration Services, LLC	0.00%	57	57	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		\$ 6,310			\$ 13,149	\$ * 6,839	39

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 Utilities	\$	Senior Living Services, Inc.	0.00%	\$ 19	\$	19	15
16	V	6 Maintenance	81,588	Senior Living Services, Inc.	0.00%	58,203		(23,385)	16
17	V	7 Mgmt. Allocation of Benefits		Senior Living Services, Inc.	0.00%	3,685		3,685	17
18	V	20 Dues, Fees, Subs & Promotions		Senior Living Services, Inc.	0.00%	7		7	18
19	V	21 Clerical and General Office		Senior Living Services, Inc.	0.00%	566		566	19
20	V	24 Travel and Seminar		Senior Living Services, Inc.	0.00%	1,399		1,399	20
21	V	25 Other Admin. Staff Transport.		Senior Living Services, Inc.	0.00%	3,044		3,044	21
22	V	26 Insurance-Prop./Liab./Malprac.		Senior Living Services, Inc.	0.00%	877		877	22
23	V	30 Depreciation		Senior Living Services, Inc.	0.00%	945		945	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		\$ 81,588			\$ 68,745	\$ *	(12,843)	39

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	19 Professional Services	\$	Bravo Holding Company	0.00%	\$ 82,857	\$	82,857	15
16	V	21 Clerical and General Office		Bravo Holding Company	0.00%	375		375	16
17	V	24 Travel and Seminar		Bravo Holding Company	0.00%	54		54	17
18	V	26 Insurance-Prop./Liab./Malprac.		Bravo Holding Company	0.00%	404		404	18
19	V	32 Interest	111,367	Bravo Holding Company	0.00%	13,917		(97,450)	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		\$ 111,367			\$ 97,607	\$ *	(13,760)	39

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 Administrative	\$	Moline Real Estate, Inc.	0.00%	\$ 3,600	\$ 3,600
16	V	19 Professional Services		Moline Real Estate, Inc.	0.00%	2,248	2,248
17	V	21 Clerical and General Office		Moline Real Estate, Inc.	0.00%	1,440	1,440
18	V	26 Insurance-Prop./Liab./Malprac.		Moline Real Estate, Inc.	0.00%	34,375	34,375
19	V	30 Depreciation		Moline Real Estate, Inc.	0.00%	63,058	63,058
20	V	32 Interest		Moline Real Estate, Inc.	0.00%	291,752	291,752
21	V	33 Real Estate Taxes		Moline Real Estate, Inc.	0.00%	31,121	31,121
22	V	34 Rent-Facility and Grounds	552,110	Moline Real Estate, Inc.	0.00%		(552,110)
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 552,110			\$ 427,594	\$ * (124,516)

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

Facility Name & ID Number

Rosewood Care Ctr of Moline

0049304

Report Period Beginning:

07/01/2013

Ending:

06/30/2014

VII. RELATED PARTIES

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

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

Facility Name & ID Number Rosewood Care Ctr of Moline # 0049304 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Michael Brady	President (Note 1)	Administrative	0.00	97,324	2.96	5.92	Salary	\$ 6,119	L17, C7	1
2	Mark Yampol	CEO (Note 2)	Administrative	0.00	28,227	2.96	5.92	Salary	1,775	L17, C7	2
3											3
4											4
5											5
6											6
7											7
8											8
9	Note 1: Michael Brady was the President of Bravo Nursing Home Services, Inc. from 7/1/13 to 12/30/13. When the stock of the companies were sold, Mr. Brady became										9
10	Director of Administrative Services and was no longer President. The wages above reflect only the period of time from when he was President.										10
11	Note 2: Mark Yampol is the CEO of Midwest Administrative Services, Inc. beginning 12/31/13, when the stock of the companies were purchased.										11
12	The wages above reflect only the period of time from 12/31/13 thru 6/30/14.										12
13								TOTAL	\$ 7,894		13

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

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

Facility Name & ID Number Rosewood Care Ctr of Moline

0049304

Report Period Beginning:

07/01/2013

Ending: 6/30/2014

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5** Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
1	10	Nursing & Medical Records	WeightedCensus	497,328	15	611,304	611,304	29,418	\$ 36,160	1
2	15	Mgmt. Allocation of Benefits	WeightedCensus	497,328	15	49,766	29,418	29,418	2,944	2
3	17	Administrative	WeightedCensus	497,328	15	206,886	206,886	29,418	12,238	3
4	19	Professional Services	WeightedCensus	497,328	15	1,560	29,418	29,418	92	4
5	20	Dues, Fees, Subs & Promotions	WeightedCensus	497,328	15	155	29,418	29,418	9	5
6	21	Clerical and General Office	WeightedCensus	497,328	15	698,165	683,784	29,418	41,298	6
7	24	Travel and Seminar	WeightedCensus	497,328	15	24,702	29,418	29,418	1,461	7
8	25	Other Admin. Staff Transport.	WeightedCensus	497,328	15	37,333	29,418	29,418	2,208	8
9	26	Insurance-Prop./Liab./Malprac.	WeightedCensus	497,328	15	4,250	29,418	29,418	251	9
10	27	Mgmt. Allocation of Benefits	WeightedCensus	497,328	15	72,507	29,418	29,418	4,289	10
11	35	Rent-Equipment & Vehicles	WeightedCensus	497,328	15	127,935	29,418	29,418	7,568	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21		** - Please note that the 15 subunits that are being allocated among include a facility in Swansea, IL. This facility was managed from								21
22		7/1/13 thru 3/31/14. The facility units used for the Swansea facility was based on the census through 3/31/14. The Swansea facility								22
23		is not a related party.								23
24										24
25	TOTALS					\$ 1,834,563	\$ 1,501,974		\$ 108,518	25

Facility Name & ID Number Rosewood Care Ctr of Moline

0049304

Report Period Beginning:

07/01/2013

Ending: 6/30/2014

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5**	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	497,328	15	24,339	24,339	29,418	\$ 1,440	1	
2	2	Food	497,328	15	417		29,418	25	2	
3	5	Utilities	497,328	15	2,858		29,418	169	3	
4	6	Maintenance	497,328	15	2,125		29,418	126	4	
5	7	Mgmt. Allocation of Benefits	497,328	15	2,750		29,418	163	5	
6	10	Nursing and Medical Records	497,328	15	61,958	61,958	29,418	3,665	6	
7	15	Mgmt. Allocation of Benefits	497,328	15	6,997		29,418	414	7	
8	17	Administrative	497,328	15	30,003	30,003	29,418	1,775	8	
9	19	Professional Services	497,328	15	118,742		29,418	7,024	9	
10	20	Dues, Fees, Subs & Promotions	497,328	15	20,968		29,418	1,240	10	
11	21	Clerical and General Office	497,328	15	1,344,593	1,045,674	29,418	79,534	11	
12	24	Travel and Seminar	497,328	15	40,571		29,418	2,400	12	
13	25	Other Admin. Staff Transport.	497,328	15	17,516		29,418	1,036	13	
14	26	Insurance-Prop./Liab./Malprac.	497,328	15	27,838		29,418	1,647	14	
15	27	Mgmt. Allocation of Benefits	497,328	15	121,473		29,418	7,185	15	
16	30	Depreciation	497,328	15	93,160		29,418	5,511	16	
17	32	Interest	497,328	15	6,702		29,418	396	17	
18	34	Rent-Facility and Grounds	497,328	15	83,780		29,418	4,956	18	
19	35	Rent-Equipment & Vehicles	497,328	15	17,213		29,418	1,018	19	
20									20	
21		** - Please note that the 15 subunits that are being allocated among include a facility in Swansea, IL. This facility was managed from 7/1/13 thru 3/31/14. The facility units used for the Swansea facility was based on the census through 3/31/14. The Swansea facility is not a related party.								21
22										22
23										23
24										24
25	TOTALS				\$ 2,024,003	\$ 1,161,974		\$ 119,724	25	

Facility Name & ID Number Rosewood Care Ctr of Moline

0049304

Report Period Beginning:

07/01/2013

Ending: 6/30/2014

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5**	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Professional Services	Weighted Census/Direct Exp 497,328	15	\$ 38,020	\$	29,418	\$ 529	1
2	20	Dues, Fees, Subs & Promotions	Weighted Census 497,328	15	3,789		29,418	224	2
3	21	Clerical and General Office	Weighted Census 497,328	15	183,917	183,869	29,418	10,879	3
4	24	Travel and Seminar	Weighted Census 497,328	15	1,515		29,418	90	4
5	25	Other Admin. Staff Transport.	Weighted Census 497,328	15	3,685		29,418	218	5
6	26	Insurance-Prop./Liab./Malprac.	Weighted Census 497,328	15	1,930		29,418	114	6
7	27	Mgmt. Allocation of Benefits	Weighted Census 497,328	15	17,550		29,418	1,038	7
8	32	Interest	Weighted Census 497,328	15	957		29,418	57	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21	** - Please note that the 15 subunits that are being allocated among include a facility in Swansea, IL. This facility was managed from 7/1/13 thru 3/31/14. The facility units used for the Swansea facility was based on the census through 3/31/14. The Swansea facility is not a related party.								21
22									22
23									23
24									24
25	TOTALS				\$ 251,363	\$ 183,869		\$ 13,149	25

Facility Name & ID Number Rosewood Care Ctr of Moline

0049304

Report Period Beginning:

07/01/2013

Ending: 6/30/2014

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5**	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	Utilities	Weighted Census	497,328	15	\$ 320	29,418	\$ 19	1	
2	6	Maintenance	Weighted Census/Direct Exp	497,328	15	998,295	573,323	29,418	58,203	2
3	7	Mgmt. Allocation of Benefits	Weighted Census	497,328	15	62,296	29,418	29,418	3,685	3
4	20	Dues, Fees, Subs & Promotions	Weighted Census	497,328	15	120	29,418	29,418	7	4
5	21	Clerical and General Office	Weighted Census	497,328	15	9,566	29,418	29,418	566	5
6	24	Travel and Seminar	Weighted Census	497,328	15	23,651	29,418	29,418	1,399	6
7	25	Other Admin. Staff Transport.	Weighted Census	497,328	15	51,467	29,418	29,418	3,044	7
8	26	Insurance-Prop./Liab./Malprac.	Weighted Census	497,328	15	14,825	29,418	29,418	877	8
9	30	Depreciation	Weighted Census	497,328	15	15,975	29,418	29,418	945	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21		** - Please note that the 15 subunits that are being allocated among include a facility in Swansea, IL. This facility was managed from 7/1/13 thru 3/31/14. The facility units used for the Swansea facility was based on the census through 3/31/14. The Swansea facility is not a related party.								21
22										22
23										23
24										24
25	TOTALS					\$ 1,176,515	\$ 573,323		\$ 68,745	25

Facility Name & ID Number Rosewood Care Ctr of Moline

0049304

Report Period Beginning: 07/01/2013

Ending: 6/30/2014

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5** Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional Services	Weighted Census	497,328	15	\$ 1,400,742	\$ 29,418	\$ 82,857	1
2	21	Clerical and General Office	Weighted Census	497,328	15	6,337	29,418	375	2
3	24	Travel and Seminar	Weighted Census	497,328	15	913	29,418	54	3
4	26	Insurance-Prop./Liab./Malprac.	Weighted Census	497,328	15	6,835	29,418	404	4
5	32	Interest	Weighted Census	497,328	15	235,278	29,418	13,917	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21	** - Please note that the 15 subunits that are being allocated among include a facility in Swansea, IL. This facility was managed from								
22	7/1/13 thru 3/31/14. The facility units used for the Swansea facility was based on the census through 3/31/14. The Swansea facility								
23	is not a related party.								
24									24
25	TOTALS					\$ 1,650,105	\$	\$ 97,607	25

Facility Name & ID Number

Rosewood Care Ctr of Moline

0049304

Report Period Beginning:

07/01/2013

Ending:

06/30/2014

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2	3	4	5	6		7	8	9	10										
						Name of Lender	Related**						Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES									NO	Original				Balance
	A. Directly Facility Related																				
	Long-Term																				
1	Berkadia			Mortgage	\$87,636.51	11/1/05	\$ 6,524,600	\$ 11,987,687	12/1/40	0.0480	\$ 288,818	1									
2												2									
3												3									
4												4									
5												5									
	Working Capital																				
6	MidCap (Thru Allocation of		X	Revolving Line of Credit		8/1/09			12/31/14	5.0000	13,917	6									
7	Bravo Holding Co.)											7									
8												8									
9	TOTAL Facility Related				\$87,636.51		\$ 6,524,600	\$ 11,987,687			\$ 302,735	9									
	B. Non-Facility Related*																				
10							Less: Interest Income Offset				(16,191)	10									
11							Amortization Expense				2,957	11									
12							Allocated from Mgmt Co's				453	12									
13												13									
14	TOTAL Non-Facility Related						\$	\$			\$ (12,781)	14									
15	TOTALS (line 9+line14)						\$ 6,524,600	\$ 11,987,687			\$ 289,954	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 30,494 Line # 26

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

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

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rosewood Care Ctr of Moline COUNTY Rock Island
 FACILITY IDPH LICENSE NUMBER 0049304
 CONTACT PERSON REGARDING THIS REPORT Mary Offner
 TELEPHONE (314) 994-9070 FAX #: (314) 994-9912

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2013 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2013.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>07-649-95-00</u>	<u>7300 34th Ave. parcel #13991</u>	\$ <u>101,576.64</u>	\$ <u>101,576.64</u>
2. <u>07-649-94-00</u>	<u>Parcel #13990</u>	\$ <u>20,362.64</u>	\$ <u>20,362.64</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>121,939.28</u></u>	\$ <u><u>121,939.28</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

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 (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? (a) Own the Equipment (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 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>	<u>4.4 Acres</u>	<u>1989</u>	<u>\$ 1,051,115</u>	1
2					2
3	TOTALS	#VALUE!		\$ 1,051,115	3

Facility Name & ID Number Rosewood Care Ctr of Moline

0049304

Report Period Beginning:

07/01/2013

Ending:

06/30/2014

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	120	1990	1990	\$ 3,036,895	\$	40	\$ 37,961	\$ 37,961	\$ 1,834,791	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Building Improvements - Real Estate Entity									9
10										10
11	Site Improvements		1990	298,795		25	5,927	5,927	288,918	11
12	Walk-in Cooler		1990	7,845		10			7,845	12
13	Sinks		1990	6,386		10			6,386	13
14	Exhaust Hood w/ Fire Extinguisher		1990	6,317		10			6,317	14
15	Generator		1990	15,779		10			15,779	15
16	Signage		1990	2,721		10			2,721	16
17	Facility Signs		1990	1,757		10			1,757	17
18	Cubicle Curtain Track		1990	6,176		10			6,176	18
19	Fire Alarm System		1990	99,726		10			99,726	19
20	Hot Water Heater		1990	6,706		10			6,706	20
21	Water Heater Tank		1990	7,961		10			7,961	21
22	Wallcovering		1990	24,650		10			24,650	22
23	Carpeting		1990	8,025		10			8,025	23
24	Curbing		1991	2,743		25	55	55	2,578	24
25	Landscaping		1991	4,560		25	91	91	4,180	25
26	Steel Trash Doors		1991	1,825		10			1,825	26
27	Irrigation System		1993	10,257		25	205	205	8,582	27
28	Water Meter & Back		1993	1,803		25	36	36	1,503	28
29	Parking Lot Addition		2000	11,485		25	230	230	6,278	29
30	Seal & Restripe Parking Lot		2003	4,530		25	91	91	1,963	30
31	Shingle Roof Replacement		2005	24,958		40	312	312	5,928	31
32	Parking Lot Improvements		2005	16,350		40	205	205	3,645	32
33	Backflow Preventer		2005	6,285		10	315	315	5,395	33
34	Console Heat Pumps		2006	6,337		10	317	317	5,281	34
35	Door Closers		2006	2,603		10	130	130	2,212	35
36	Carpet		2007	5,464		10	273	273	4,007	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Rosewood Care Ctr of Moline

0049304

Report Period Beginning:

07/01/2013

Ending:

06/30/2014

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	<u>Building Improvements - Real Estate Entity, continued</u>		\$	\$		\$	\$	\$	37
38									38
39	<u>Seal and Stripe Parking Lot</u>	2008	3,715		25	75	75	892	39
40	<u>Telephone System</u>	2008	20,911		10	1,046	1,046	12,895	40
41	<u>Doors</u>	2009	5,097		10	255	255	2,676	41
42	<u>Grease Trap</u>	2009	4,875		10	244	244	2,600	42
43	<u>New Windows</u>	2009	2,625		10	131	131	1,247	43
44	<u>Replace Sidewalks</u>	2009	10,980		25	220	220	2,159	44
45	<u>Carpet - office, resident lounge, dining room & waiting areas</u>	2010	11,593		10	580	580	5,217	45
46	<u>Doors - Rooms 201, 405, 534 & 535</u>	2010	4,402		10	220	220	1,797	46
47	<u>Countertops in beverage room and therapy room</u>	2010	2,570		10	129	129	1,049	47
48	<u>Sealcoat Parking Lot</u>	2010	4,855		25	97	97	793	48
49	<u>HVAC</u>	2010	3,035		10	152	152	1,113	49
50	<u>Sinks</u>	2011	7,968		10	398	398	1,430	50
51	<u>Crack Repair & control joint caulking entire building</u>	2011	24,950		40	312	312	1,767	51
52	<u>Sprinkler System</u>	2011	8,427		10	421	421	2,265	52
53	<u>Doors - Exterior</u>	2011	29,823		10	1,491	1,491	8,201	53
54	<u>HVAC</u>	2012	28,173		10	1,409	1,409	7,043	54
55	<u>Doors - Exterior</u>	2012	3,096		10	155	155	697	55
56	<u>Nurse Call System</u>	2012	3,256		10	163	163	733	56
57	<u>Hot Water Boiler</u>	2012	9,404		40	118	118	457	57
58	<u>Seal Coat Parking Lot</u>	2012	6,678		25	134	134	490	58
59	<u>HVAC Improvements</u>	2014	5,301		10	66	66	132	59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,830,673	\$		\$ 53,964	\$ 53,964	\$ 2,426,788	70

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

Facility Name & ID Number Rosewood Care Ctr of Moline

0049304

Report Period Beginning:

07/01/2013

Ending:

06/30/2014

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,830,673	\$		\$ 53,964	\$ 53,964	\$ 2,426,788	1
2	Leasehold Improvements - Operating Entity								2
3									3
4	Tile Repair	2008	2,540	362	7	362		2,328	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,833,213	\$ 362		\$ 54,326	\$ 53,964	\$ 2,429,116	34

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

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	\$ 52,385	\$ 10,478	\$ 10,478	\$	5	\$ 12,641	71
72	Current Year Purchases	5,712	854	854		5	854	72
73	Fully Depreciated Assets							73
74	Allocated from Mgmt Co/Real Estate Entity	838,518		15,550	15,550		763,225	74
75	TOTALS	\$ 896,615	\$ 11,332	\$ 26,882	\$ 15,550		\$ 776,720	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,780,943	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 11,694	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 81,208	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 69,514	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,205,836	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Rosewood Care Ctr of Moline

0049304

Report Period Beginning: 07/01/2013

Ending: 06/30/2014

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Moline Real Estate, Inc.

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:	<u>1990</u>	<u>120</u>	<u>12/1/07</u>	\$ <u>538,864</u>	<u>5</u>	<u>Unlimited</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		<u>120</u>		\$ <u>538,864</u>			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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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 N/A.

N/A

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

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: \$ 34,114 Description: Medical Equipment \$23,710; Offsite Storage \$1,818, Home Office Allocation - \$8,586

(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	<u>N/A</u>		\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

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

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

Facility Name & ID Number Rosewood Care Ctr of Moline # 0049304 Report Period Beginning: 07/01/2013 Ending: 06/30/2014
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.

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

	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	10A(3)	hrs	\$	5,859	\$ 275,611	\$	5,859	\$ 275,611	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,095	71,382		1,095	71,382	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		6,006	270,148	1,722	6,006	271,870	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				202,482		202,482	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	12,960	\$ 617,141	\$ 204,204	12,960	\$ 821,345	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Rosewood Care Ctr of Moline# 0049304Report Period Beginning: 07/01/2013

Ending:

06/30/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2014

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 10,347	\$ 34,443	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>270,105</u>)	1,550,097	1,550,097	3
4	Supply Inventory (priced at <u>Cost</u>)	3,106	3,106	4
5	Short-Term Investments			5
6	Prepaid Insurance	16,929	19,318	6
7	Other Prepaid Expenses	3,434	3,434	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,583,913	\$ 1,610,398	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,051,115	13
14	Buildings, at Historical Cost		3,036,895	14
15	Leasehold Improvements, at Historical Cost	2,540	796,318	15
16	Equipment, at Historical Cost	58,097	896,615	16
17	Accumulated Depreciation (book methods)	(15,823)	(3,205,836)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		183,586	21
22	Other Long-Term Assets (spec <u>Loan Fees</u>)		238,769	22
23	Other(specify): <u>Deposits</u>	2,000	2,000	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 46,814	\$ 2,999,462	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,630,727	\$ 4,609,860	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 445,600	\$ 477,192	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	206,126	206,126	30
31	Accrued Taxes Payable (excluding real estate taxes)	36,500	36,500	31
32	Accrued Real Estate Taxes(Sch.IX-B)		124,378	32
33	Accrued Interest Payable		53,033	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	9,067	24,197	35
	Other Current Liabilities(specify):			
36	<u>Accrued Expenses</u>	155,406	172,306	36
37	<u>Accrued Rent</u>	362,393		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,215,092	\$ 1,093,732	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,987,687	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Due to Bravo Holding Company</u>	2,264,321	2,264,321	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,264,321	\$ 14,252,008	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,479,413	\$ 15,345,740	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,848,686)	\$ (10,735,880)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,630,727	\$ 4,609,860	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,350,382)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,350,382)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(498,304)	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)	\$ (498,304)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,848,686)	24 *

* This must agree with page 17, line 47.

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.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,498,472	1
2	Discounts and Allowances for all Levels	(1,633,774)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,864,698	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	214,440	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 214,440	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,400	13
14	Non-Patient Meals	7,538	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	56,391	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 66,329	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	16,168	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 16,168	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Attached Schedule</u>	2,080	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,080	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,163,715	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,033,102	31
32	Health Care	2,538,392	32
33	General Administration	995,025	33
B. Capital Expense			
34	Ownership	1,296,478	34
C. Ancillary Expense			
35	Special Cost Centers	584,285	35
36	Provider Participation Fee	214,737	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,662,019	40
41	Income before Income Taxes (line 30 minus line 40)**	(498,304)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (498,304)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,145,830	44
45	Private Pay - Net Inpatient Revenue	1,303,350	45
46	Medicare - Net Inpatient Revenue	1,841,308	46
47	Other-(specify) <u>Insurance</u>	574,210	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,864,698	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Rosewood Care Ctr of Moline

Period Beginning 07/01/2013

Period End 06/30/2014

Schedule 19A

Other Revenue:

Vending Income	766
Vendor Discount	1,225
Miscellaneous	89
	<hr/>
Total Other Revenue	<u>2,080</u>

Facility Name & ID Number Rosewood Care Ctr of Moline

0049304

Report Period Beginning: 07/01/2013

Ending: 06/30/2014

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,222	2,384	\$ 62,137	\$ 26.06	1
2	Assistant Director of Nursing	1,789	1,908	48,584	25.46	2
3	Registered Nurses	11,679	12,103	262,000	21.65	3
4	Licensed Practical Nurses	21,813	22,867	414,488	18.13	4
5	CNAs & Orderlies	62,694	65,597	686,778	10.47	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	885	1,033	9,106	8.82	8
9	Activity Director	2,080	2,144	24,758	11.55	9
10	Activity Assistants	2,945	3,006	24,827	8.26	10
11	Social Service Workers	3,481	3,603	41,432	11.50	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,201	22,771	239,661	10.52	15
16	Dishwashers					16
17	Maintenance Workers	2,157	2,230	29,479	13.22	17
18	Housekeepers	15,418	16,195	138,660	8.56	18
19	Laundry	4,074	4,361	37,498	8.60	19
20	Administrator	2,080	2,120	87,570	41.31	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,427	8,872	85,894	9.68	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,511	2,643	25,226	9.54	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Sch 20A</u>	11,242	12,024	218,485	18.17	33
34	TOTAL (lines 1 - 33)	176,698	185,861	\$ 2,436,583 *	\$ 13.11	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 8,349	L1, C3	35
36	Medical Director	Monthly	11,250	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,663	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,300	L11, C3	44
45	Social Service Consultant	Monthly	2,350	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 31,912		49

C. CONTRACT NURSES

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

Rosewood Care Ctr of Moline

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

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Nurse	2,156	2,368	43,038	18.17
Case Manager	1,141	1,197	28,084	23.46
Rehabilitation Nurse	2,127	2,291	36,947	16.13
Ward Clerk	1,633	1,665	28,907	17.36
Marketing	4,185	4,503	81,509	18.10
TOTAL	<u>11,242</u>	<u>12,024</u>	<u>218,485</u>	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Chad Joe Coulter</u>	<u>Administrator</u>	<u>0</u>	<u>\$ 87,570</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 62,980</u>	<u>IDPH License Fee</u>	<u>\$ 3,980</u>	
				<u>Unemployment Compensation Insurance</u>	<u>88,362</u>	<u>Advertising: Employee Recruitment</u>	<u>10,755</u>	
				<u>FICA Taxes</u>	<u>182,330</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>19,817</u>	<u>(Indicate # of checks performed)</u>	<u>3,277</u>	
				<u>Employee Meals</u>		<u>Patient Background Checks</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Misc. Dues/Subscriptions/Fees</u>	<u>500</u>	
				<u>Employee Relations</u>	<u>1,462</u>	<u>Rosewood License Fee</u>	<u>1,500</u>	
				<u>Employee Uniforms</u>	<u>597</u>	<u>IHCA Dues</u>	<u>4,232</u>	
				<u>Employee Physicals</u>	<u>4,282</u>	<u>Misc. Licenses & Fees</u>	<u>760</u>	
				<u>Employee Drug Tests</u>	<u>114</u>	<u>Home Office Allocation</u>	<u>1,480</u>	
				<u>Tuition Reimbursement</u>		<u>Less: Public Relations Expense</u>	<u>()</u>	
						<u>Non-allowable advertising</u>	<u>()</u>	
						<u>Yellow page advertising</u>	<u>()</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 87,570	TOTAL (agree to Schedule V, line 22, col.8)	\$ 359,944	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 26,484	
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>Mgmt Fees-Bravo Nursing Home Svc-See Page 6, Elimon P 3, C 7</u>			<u>\$ 138,000</u>	<u>N/A</u>			<u>Out-of-State Travel</u>	<u>\$</u>
<u>Mgmt Fees-Midwest Admin Svc-See Page 6, Elimon P 3, C 7 from 1/1/14-6/30/14 (post-acquisition)</u>			<u>91,432</u>				<u>In-State Travel</u>	<u>128</u>
							<u>Home Office Allocation</u>	<u>5,404</u>
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 229,432				<u>Seminar Expense</u>	<u>150</u>
(Attach a copy of any management service agreement)							<u>Entertainment Expense</u>	<u>()</u>
C. Professional Services				TOTAL			TOTAL	
Vendor/Payee	Type		Amount					
<u>Hochschild, Bloom & Company</u>	<u>Accountant/Consultant</u>		<u>\$ 3,394</u>					
<u>Midwest Administrative Services</u>	<u>Administrative/Bookkeeping</u>		<u>78,850</u>					
<u>Claims Administration Services, Inc.</u>	<u>Related Party Legal Fees</u>		<u>6,310</u>					
<u>Daniel Maher</u>	<u>Legal Fees</u>		<u>7,219</u>					
<u>Healthcare Horizons</u>	<u>Healthcare Consultant</u>		<u>1,135</u>					
<u>Rock Island County Circuit Court</u>	<u>Legal-Court Costs</u>		<u>136</u>					
<u>Senior Care Capital</u>	<u>Loan Fees</u>		<u>7,500</u>					
<u>Small Newspaper Group, Inc.</u>	<u>Public Notice</u>		<u>39</u>					
<u>US Managed Care Services, LLC</u>	<u>Managed Care Network</u>		<u>200</u>					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 104,783					
(For legal fee disclosure, see page 39 of instructions)								

* Attach copy of IMRF notifications

**See instructions.

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

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

Facility Name & ID Number Rosewood Care Ctr of Moline# 0049304Report Period Beginning: 07/01/2013 Ending: 06/30/2014**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. 4,232 IHCA
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 42,938 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. \$ 214,737
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 8,304
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.