

		FOR BHF USE					

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2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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.

<p>I. IDPH License ID Number: <u>0049312</u></p> <p>Facility Name: <u>Rosewood Care Ctr of Peoria</u></p> <p>Address: <u>1500 W Northmoor</u> <u>Peoria</u> <u>61614</u> <small>Number City Zip Code</small></p> <p>County: <u>Peoria</u></p> <p>Telephone Number: <u>(309)691-2200</u> Fax # <u>(309)691-1548</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>12/1/07</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Cindy A. Tefteller</u> Telephone Number: <u>(618)465-7717</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/2012</u> to <u>6/30/2013</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ (Type or Print Name) _____ (Title) _____ </td> </tr> <tr> <td style="width:20%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) <u>See Accountant's Compilation Report</u> (Print Name and Title) <u>Cindy A. Tefteller</u> (Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 E. Center Drive, Alton, IL 62002</u> (Telephone) <u>(618)465-7717</u> Fax # <u>(618)465-7710</u> </td> </tr> </table> <p align="right"> 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 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) <u>See Accountant's Compilation Report</u> (Print Name and Title) <u>Cindy A. Tefteller</u> (Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 E. Center Drive, Alton, IL 62002</u> (Telephone) <u>(618)465-7717</u> Fax # <u>(618)465-7710</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____							
Paid Preparer	(Signed) <u>See Accountant's Compilation Report</u> (Print Name and Title) <u>Cindy A. Tefteller</u> (Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 E. Center Drive, Alton, IL 62002</u> (Telephone) <u>(618)465-7717</u> Fax # <u>(618)465-7710</u>							

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Peoria

0049312 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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			7,393	7,393	8
9	SNF/PED					9
10	ICF	10,360	12,410		22,770	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,360	12,410	7,393	30,163	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.87%

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

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 52 and days of care provided 7,393

Medicare Intermediary Novitas Solutions, Inc.

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/13 Fiscal Year: 6/30/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Rosewood Care Ctr of Peoria

0049312

Report Period Beginning:

7/1/2012

Ending:

6/30/2013

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	223,626	29,775	6,941	260,342		260,342	260,342		1	
2	Food Purchase		192,757		192,757		192,757	(12,249)	180,508	2	
3	Housekeeping	153,395	33,088		186,483		186,483		186,483	3	
4	Laundry	42,904	25,794		68,698		68,698		68,698	4	
5	Heat and Other Utilities			118,662	118,662		118,662		118,662	5	
6	Maintenance	35,725	15,583	289,786	341,094		341,094	(67,220)	273,874	6	
7	Other (specify):* Waste Disposal			12,411	12,411		12,411		12,411	7	
8	TOTAL General Services	455,650	296,997	427,800	1,180,447		1,180,447	(79,469)	1,100,978	8	
	B. Health Care and Programs										
9	Medical Director			17,250	17,250		17,250		17,250	9	
10	Nursing and Medical Records	1,851,703	180,992	7,831	2,040,526		2,040,526	33,766	2,074,292	10	
10a	Therapy	51,641	2,182		53,823		53,823		53,823	10a	
11	Activities	68,557	3,142	2,400	74,099		74,099		74,099	11	
12	Social Services	52,432	188	2,400	55,020		55,020		55,020	12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):*									15	
16	TOTAL Health Care and Programs	2,024,333	186,504	29,881	2,240,718		2,240,718	33,766	2,274,484	16	
	C. General Administration										
17	Administrative	67,506		138,000	205,506		205,506	(126,208)	79,298	17	
18	Directors Fees									18	
19	Professional Services			267,692	267,692		267,692	262	267,954	19	
20	Dues, Fees, Subscriptions & Promotions			31,771	31,771	625	32,396	(6,285)	26,111	20	
21	Clerical & General Office Expenses	143,765	22,416	17,679	183,860		183,860	(23,606)	160,254	21	
22	Employee Benefits & Payroll Taxes			387,912	387,912		387,912	17,269	405,181	22	
23	Inservice Training & Education									23	
24	Travel and Seminar			1,145	1,145	(625)	520	4,323	4,843	24	
25	Other Admin. Staff Transportation			12,568	12,568		12,568	2,893	15,461	25	
26	Insurance-Prop.Liab.Malpractice			70,699	70,699		70,699	1,987	72,686	26	
27	Other (specify):*									27	
28	TOTAL General Administration	211,271	22,416	927,466	1,161,153		1,161,153	(129,365)	1,031,788	28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,691,254	505,917	1,385,147	4,582,318		4,582,318	(175,068)	4,407,250	29	

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rosewood Care Ctr of Peoria

#0049312

Report Period Beginning:

7/1/2012

Ending:

6/30/2013

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			5,604	5,604		5,604	2,641	8,245			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			18,784	18,784		18,784	(14,620)	4,164			32
33	Real Estate Taxes			98,534	98,534		98,534		98,534			33
34	Rent-Facility & Grounds			1,168,825	1,168,825		1,168,825		1,168,825			34
35	Rent-Equipment & Vehicles			17,887	17,887		17,887		17,887			35
36	Other (specify):*											36
37	TOTAL Ownership			1,309,634	1,309,634		1,309,634	(11,979)	1,297,655			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		272,772	983,412	1,256,184		1,256,184		1,256,184			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			198,330	198,330		198,330		198,330			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		272,772	1,181,742	1,454,514		1,454,514		1,454,514			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,691,254	778,689	3,876,523	7,346,466		7,346,466	(187,047)	7,159,419			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	(10,244)	2		4
5	Telephone, TV & Radio in Resident Rooms				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	(3,925)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,612)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(393)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,551)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(952)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,678)	20		28
29	Other-Attach Schedule	(72,336)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (95,691)		\$	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	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)	(91,356)	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (91,356)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (187,047)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Care Ctr of Peoria

ID# 0049312

Report Period Beginning: 7/1/2012

Ending: 6/30/2013

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Eliminate Marketing Salary	\$ (61,436)	21	1
2	Eliminate Marketing Payroll Taxes	(4,700)	22	2
3	Eliminate Marketing Mileage	(5,221)	25	3
4	Eliminate Lobbying & PAC Dues	(2,969)	20	4
5	Add Current Year IDPH Licence Fee Paid in Prior Year	1,990	20	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		(72,336)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Ctr of Peoria# 0049312

Report Period Beginning:

7/1/2012

Ending:

6/30/2013

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(12,249)	0	0	0	0	0	0	0	0	0	0	(12,249)	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	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	(67,220)	0	0	0	0	0	0	0	0	(67,220)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(12,249)	0	(67,220)	0	(79,469)	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	33,766	0	0	0	0	0	0	0	0	0	33,766	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	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	33,766	0	0	0	0	0	0	0	0	0	33,766	16
	C. General Administration													
17	Administrative	0	(126,208)	0	0	0	0	0	0	0	0	0	(126,208)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,551)	404	1,409	0	0	0	0	0	0	0	0	262	19
20	Fees, Subscriptions & Promotions	(6,609)	17	307	0	0	0	0	0	0	0	0	(6,285)	20
21	Clerical & General Office Expenses	(61,436)	36,652	1,178	0	0	0	0	0	0	0	0	(23,606)	21
22	Employee Benefits & Payroll Taxes	(4,700)	15,107	6,862	0	0	0	0	0	0	0	0	17,269	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,203	3,120	0	0	0	0	0	0	0	0	4,323	24
25	Other Admin. Staff Transportation	(5,221)	2,521	5,593	0	0	0	0	0	0	0	0	2,893	25
26	Insurance-Prop.Liab.Malpractice	0	267	1,720	0	0	0	0	0	0	0	0	1,987	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(79,517)	(70,037)	20,189	0	(129,365)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(91,766)	(36,271)	(47,031)	0	(175,068)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Ctr of Peoria# 0049312

Report Period Beginning:

7/1/2012 Ending:6/30/2013

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	2,641	0	0	0	0	0	0	0	0	2,641	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,925)	0	(10,695)	0	0	0	0	0	0	0	0	(14,620)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(3,925)	0	(8,054)	0	(11,979)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(95,691)	(36,271)	(55,085)	0	0	0	0	0	0	0	0	(187,047)	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	Bravo Care of Alton, Inc.	Alton, IL	Bravo Care of Wood River, Inc.	Wood River, IL	Supportive Living Facility
		Bravo Care of East Peoria, Inc.	East Peoria, IL	Bravo Nursing Home Services, Inc.	St. Louis, MO	Management Co.
		Bravo Care of Edwardsville, Inc.	Edwardsville, IL	Bravo Holding Company, Inc.	St. Louis, MO	Holding Co.
		Bravo Care of Elgin, Inc.	Elgin, IL			
		Bravo Care of Galesburg, Inc.	Galesburg, IL			
		Bravo Care of Inverness, Inc.	Inverness, IL			
		Bravo Care of Joliet, Inc.	Joliet, IL			

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 See Schedule VIII	\$	Bravo Nursing Home Services, Inc.	100.00%	\$ 33,766	\$ 33,766	1
2	V	17 Management Fees	138,000	Bravo Nursing Home Services, Inc.	100.00%	11,792	(126,208)	2
3	V	19 See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	404	404	3
4	V	20 See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	17	17	4
5	V	21 See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	36,652	36,652	5
6	V	22 See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	15,107	15,107	6
7	V	24 See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	1,203	1,203	7
8	V	25 See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	2,521	2,521	8
9	V	26 See Schedule VIII		Bravo Nursing Home Services, Inc.	100.00%	267	267	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 138,000			\$ 101,729	\$ * (36,271)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Peoria# 0049312Report Period Beginning: 7/1/2012Ending: 6/30/2013

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	6 Repairs & Maintenance	\$ 209,997	Senior Living Services, Inc.		\$ 142,777	\$ (67,220)
16	V	21 Clerical & Office Expenses		Senior Living Services, Inc.		1,069	1,069
17	V	22 Payroll Taxes & Emp Ben.		Senior Living Services, Inc.		5,882	5,882
18	V	24 Travel & Seminar		Senior Living Services, Inc.		3,007	3,007
19	V	25 Other Admin Staff Transportation		Senior Living Services, Inc.		5,455	5,455
20	V	26 Insurance		Senior Living Services, Inc.		1,170	1,170
21	V	30 Depreciation		Senior Living Services, Inc.		2,641	2,641
22	V						
23	V	19 Professional Services	12,543	Claims Administrative Services, LLC		7,650	(4,893)
24	V						
25	V	21 Clerical & Office Expenses		Claims Administrative Services, LLC		109	109
26	V	22 Payroll Taxes & Emp Ben.		Claims Administrative Services, LLC		980	980
27	V	24 Travel & Seminar		Claims Administrative Services, LLC		113	113
28	V	25 Other Admin Staff Transportation		Claims Administrative Services, LLC		138	138
29	V						
30	V	19 Professional Services		Bravo Holding Company		6,302	6,302
31	V	20 Dues, Fees & Subscriptions		Bravo Holding Company		307	307
32	V	26 Insurance		Bravo Holding Company		550	550
33	V	32 Interest	18,784	Bravo Holding Company		8,089	(10,695)
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 241,324			\$ 186,239	\$ * (55,085)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Rosewood Care Ctr of Peoria

0049312

Report Period Beginning:

7/1/2012

Ending:

6/30/2013

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			Bravo Care of Moline, Inc.	Moline, IL	Senior Living		Building Services	1
2			Bravo Care of Northbrook, Inc.	Northbrook, IL	Services, Inc.	St. Louis, MO	Company	2
3			Bravo Care of Rockford, Inc.	Rockford, IL	Bravo Team		Human Resources	3
4			Bravo Care of St. Charles, Inc.	St. Charles, IL	Health, Inc.	St. Louis, MO	Company	4
5			Bravo Care of St. Louis, Inc.	St. Louis, MO				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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Peoria # 0049312 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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, Bravo	Administrative	0.00	171,824	3.85	6.42	Salary	\$ 11,792	17,8	1
2		N.H. Services, Inc.									2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 11,792		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Peoria

0049312

Report Period Beginning:

7/1/2012

Ending: 7/30/2013

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

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	10	Nursing & Medical Records	Total Cost	15	\$ 525,769	\$ 525,769	7,052,937	\$ 33,766	1
2	17	Salaries-Officer	Total Cost	15	183,617	183,617	7,052,937	11,792	2
3	19	Professional Services	Total Cost	15	6,285		7,052,937	404	3
4	20	Dues & Subscriptions	Total Cost	15	264		7,052,937	17	4
5	21	Salaries-Other	Total Cost	15	558,202	558,202	7,052,937	35,849	5
6	21	Taxes, Licenses, & Office Sup	Total Cost	15	1,944		7,052,937	125	6
7	21	Telephone	Total Cost	15	10,557		7,052,937	678	7
8	22	Payroll Taxes	Total Cost	15	91,380		7,052,937	5,869	8
9	22	Employee Benefits	Total Cost	15	143,842		7,052,937	9,238	9
10	24	Travel & Seminar	Total Cost	15	18,727		7,052,937	1,203	10
11	25	Administrative Transportation	Total Cost	15	39,261		7,052,937	2,521	11
12	26	Insurance	Total Cost	15	4,163		7,052,937	267	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,584,011	\$ 1,267,588		\$ 101,729	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Rosewood Care Ctr of Peoria

0049312

Report Period Beginning:

7/1/2012

Ending:

6/30/2013

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		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						\$	\$			\$	1							
2											2							
3											3							
4											4							
5											5							
Working Capital																		
6	Bravo Holding Co.		Revolving Line of Credit	8/1/2009			315,940	12/31/14	5.0000	8,089	6							
7											7							
8	Less: Interest Income Offset									(3,925)	8							
9	TOTAL Facility Related				\$40,026.00	\$	\$ 315,940			\$ 4,164	9							
B. Non-Facility Related*																		
10											10							
11											11							
12											12							
13											13							
14	TOTAL Non-Facility Related					\$	\$			\$	14							
15	TOTALS (line 9+line14)					\$	\$ 315,940			\$ 4,164	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # N/A

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

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

Facility Name & ID Number Rosewood Care Ctr of Peoria# 0049312

Report Period Beginning:

7/1/2012

Ending:

6/30/2013

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	<u>98,566</u>	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.)		\$	<u>98,238</u>			2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>(328)</u>			3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>98,862</u>			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.		\$	<u>98,534</u>			7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2008	<u>91,703</u>	8	FOR BHF USE ONLY	
		2009	<u>96,584</u>	9		
		2010	<u>97,909</u>	10	13	FROM R. E. TAX STATEMENT FOR 2012 \$ 13
		2011	<u>98,592</u>	11	14	PLUS APPEAL COST FROM LINE 5 \$ 14
		2012	<u>97,884</u>	12	15	LESS REFUND FROM LINE 6 \$ 15
<u>2011 Taxes paid = \$49296</u>					16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
<u>2012 Taxes paid = \$48942</u>						
<u>Accrual = Remaining 2012 taxes (\$48,942) + 1/2 estimated 2013 taxes (\$49,920)</u>						

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rosewood Care Ctr of Peoria COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0049312

CONTACT PERSON REGARDING THIS REPORT Chuck Schmitz

TELEPHONE (314)994-9070 FAX #: (314)994-9112

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2012 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 2012.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>14-17-326-009</u>	<u>1500 W. Northmoor Road</u>	\$ <u>95,301.64</u>	\$ <u>95,301.64</u>
2. <u>14-17-326-010</u>	<u>SW 1/4 SEC 17-9N-8E</u>	\$ <u>1,769.60</u>	\$ <u>1,769.60</u>
3. <u>14-17-376-001</u>	<u>SW 1/4 SEC 17-9-8E</u>	\$ <u>812.26</u>	\$ <u>812.26</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>97,883.50</u></u>	\$ <u><u>97,883.50</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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

Facility Name & ID Number Rosewood Care Ctr of Peoria

0049312 Report Period Beginning:

7/1/2012 Ending:

6/30/2013

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,500 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: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Schedule N/A</u>			\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Peoria

0049312

Report Period Beginning:

7/1/2012

Ending:

6/30/2013

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					\$	\$		\$	\$	\$	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

SEE ACCOUNTANTS' COMPILATION REPORT

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	Building Improvements made by lessor 12/1/07-6/30/13		\$	\$		\$	\$	\$	37
38	Heat Pumps	2007	3,320						38
39	Cooling Tower	2008	50,686						39
40	Cooling Unit for Walk-In Cooler	2008	3,700						40
41	Seal and Stripe Parking Lot	2008	6,490						41
42	Cabinet/Countertops	2009	4,347						42
43	Telephone System	2009	30,716						43
44	Generator	2009	4,781						44
45	Sprinkler Pipe	2010	2,928						45
46	Asphalt Parking Lot	2010	61,200						46
47	Sidewalks	2010	7,200						47
48	Water Heater	2011	3,016						48
49	Doors	2011	19,324						49
50	Replace Boiler	2012	7,842						50
51	Sprinkler	2012	3,830						51
52	Sidewalks	2012	5,239						52
53	Tuckpointing	2012	4,482						53
54	Shower Renovation - new flooring, new Az Rock wall system,	2012	45,215						54
55	new shower heads, handles & drains								55
56	Water Filtration System	2013	3,997						56
57	HVAC Unit	2013	5,257						57
58	Sprinkler	2012	16,874						58
59									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)		\$ 290,444	\$		\$	\$	\$	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rosewood Care Ctr of Peoria

0049312

Report Period Beginning:

7/1/2012

Ending:

6/30/2013

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	\$	\$	\$	\$		\$	71
72	Current Year Purchases	<u>57,437</u>	<u>5,604</u>	<u>5,604</u>		<u>5</u>	<u>5,604</u>	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ <u>57,437</u>	\$ <u>5,604</u>	\$ <u>5,604</u>	\$		\$ <u>5,604</u>	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	<u>Senior Living Services</u>	<u>Various</u>	<u>Various</u>	\$ <u>17,593</u>	\$	\$ <u>2,641</u>	\$ <u>2,641</u>	<u>4</u>	\$ <u>14,992</u>	76
77										77
78										78
79										79
80	TOTALS			\$ <u>17,593</u>	\$	\$ <u>2,641</u>	\$ <u>2,641</u>		\$ <u>14,992</u>	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)	\$ 365,474	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 5,604	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 8,245	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,641	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 20,596	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	<u>Section Not Applicable</u>	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	<u>Section Not Applicable</u>	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Peoria 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>1989</u>	<u>120</u>	<u>12/1/07</u>	\$ <u>1,168,825</u>	<u>5</u>	<u>Unlimited</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		120		\$ 1,168,825			7

10. Effective dates of current rental agreement:

Beginning 12/1/07

Ending 11/30/13

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

Fiscal Year Ending Annual Rent

12. 6/30/2014 \$ 416,302

13. 6/30/2014 \$ _____

14. 6/30/2016 \$ _____

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.

None

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: \$ Not Specified 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	<u>Section Not Applicable</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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Peoria # 0049312 Report Period Beginning: 7/1/2012 Ending: 6/30/2013
 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? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			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		hrs	\$		\$										1
2	Licensed Speech and Language Development Therapist		hrs													2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	10a,2	hrs							2,182					2,182	4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy	39,2	# of prescrpts							272,772					272,772	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify):															12
13	Physical, Occupational & Speech Therapy Other (specify): <u>Labs,X-Rays,Enterals</u>	39,3							983,412						983,412	13
14	TOTAL			\$		\$	983,412	\$	274,954	\$			\$	1,258,366	14	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Peoria

0049312

Report Period Beginning: 7/1/2012

Ending:

6/30/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2013

(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	\$ 60,101	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (33,884))	1,391,694		3
4	Supply Inventory (priced at Cost)	3,494		4
5	Short-Term Investments			5
6	Prepaid Insurance	31,303		6
7	Other Prepaid Expenses	6,307		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,492,899	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	60,722		16
17	Accumulated Depreciation (book methods)	(5,604)		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): <u>Police Reports Deposit</u>	2,000		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 57,118	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,550,017	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 202,948	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	211,995		30
31	Accrued Taxes Payable (excluding real estate taxes)	30,901		31
32	Accrued Real Estate Taxes(Sch.IX-B)	98,862		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	10,512		35
Other Current Liabilities(specify):				
36	<u>Accrued Expense</u>	122,280		36
37	<u>Accrued Rent</u>	267,977		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 945,475	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	315,940		39
40	Mortgage Payable			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)	\$ 315,940	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,261,415	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 288,602	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,550,017	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 189,765	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 189,765	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	\$ 98,837	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)	\$ 98,837	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)	\$ 288,602	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 7,490,818	1
2	Discounts and Allowances for all Levels	(2,648,278)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,842,540	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,593,731	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,593,731	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,200	13
14	Non-Patient Meals	10,244	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		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 11,444	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	3,925	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,925	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See attachment</u>	4,175	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,175	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,455,815	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,180,447	31
32	Health Care	2,240,718	32
33	General Administration	1,161,153	33
B. Capital Expense			
34	Ownership	1,309,634	34
C. Ancillary Expense			
35	Special Cost Centers	1,256,184	35
36	Provider Participation Fee	198,330	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,346,466	40
41	Income before Income Taxes (line 30 minus line 40)**	109,349	41
42	Income Taxes	(10,512)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 98,837	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,107,660	44
45	Private Pay - Net Inpatient Revenue	2,185,450	45
46	Medicare - Net Inpatient Revenue	1,326,557	46
47	Other-(specify) <u>Management Care</u>	222,873	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,842,540	49

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Peoria

0049312

Report Period Beginning:

7/1/2012

Ending:

6/30/2013

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	1,462	1,481	\$ 48,569	\$ 32.79	1
2	Assistant Director of Nursing	1,995	2,093	56,000	26.76	2
3	Registered Nurses	15,508	16,574	417,757	25.21	3
4	Licensed Practical Nurses	19,987	21,719	466,088	21.46	4
5	CNAs & Orderlies	66,713	70,375	780,013	11.08	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,832	2,994	51,641	17.25	8
9	Activity Director					9
10	Activity Assistants	4,879	5,409	68,557	12.67	10
11	Social Service Workers	4,326	4,514	52,432	11.62	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,263	20,849	223,626	10.73	15
16	Dishwashers					16
17	Maintenance Workers	1,999	2,147	35,725	16.64	17
18	Housekeepers	15,103	16,009	153,395	9.58	18
19	Laundry	4,788	5,021	42,904	8.54	19
20	Administrator	1,728	1,782	67,506	37.88	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,538	11,138	143,765	12.91	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	5,226	5,699	83,276	14.61	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	176,347	187,804	\$ 2,691,254 *	\$ 14.33	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	Contract	\$ 6,941	1,3	35
36	Medical Director	Contract	17,250	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	7,831	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Contract	2,400	11,3	44
45	Social Service Consultant	Contract	2,400	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 36,822		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	Schedule Not Applicable	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Peoria

0049312

Report Period Beginning:

7/1/2012

Ending:

6/30/2013

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 \$3900
- (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. \$ 49,164 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. \$ 198,330
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (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. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 10,244
- (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? N/A 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. \$ No
- (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) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

Bravo Care Center of Peoria
Attachment to Schedule XII D
Other Revenue
6/30/2013

Description		
28A	Miscellaneous Income	\$ (670)
28B	Vendor Discount	1612
28C	Vending Income	3233
		<u>4175</u>