



Facility Name & ID Number Rosewood Care Ctr E Peoria

# 0049338 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	110	998	6,649	7,757	8
9	SNF/PED					9
10	ICF	13,196	13,525	8	26,729	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,306	14,523	6,657	34,486	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.74%

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 12/01/2007

J. Was the facility purchased or leased after January 1, 1978?

YES  Date 12/01/2007 NO

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified 36 and days of care provided 5,175

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
	<b>A. General Services</b>										
1	Dietary	216,007	27,880	7,950	251,837		251,837	1,688	253,525	1	
2	Food Purchase		224,975		224,975		224,975	(12,402)	212,573	2	
3	Housekeeping	144,651	35,290		179,941		179,941		179,941	3	
4	Laundry	49,616	14,746		64,362		64,362		64,362	4	
5	Heat and Other Utilities			122,261	122,261		122,261	220	122,481	5	
6	Maintenance	31,011	9,655	196,856	237,522		237,522	(30,666)	206,856	6	
7	Other (specify):* Allocated HO Benefits							4,511	4,511	7	
8	<b>TOTAL General Services</b>	441,285	312,546	327,067	1,080,898		1,080,898	(36,649)	1,044,249	8	
	<b>B. Health Care and Programs</b>										
9	Medical Director			18,000	18,000		18,000		18,000	9	
10	Nursing and Medical Records	2,372,396	188,932	14,377	2,575,705		2,575,705	46,685	2,622,390	10	
10a	Therapy		2,344	800,805	803,149		803,149		803,149	10a	
11	Activities	51,368	3,312	2,400	57,080		57,080		57,080	11	
12	Social Services	49,316		2,400	51,716		51,716		51,716	12	
13	CNA Training									13	
14	Program Transportation			2,984	2,984		2,984		2,984	14	
15	Other (specify):* Allocated HO Benefits							3,936	3,936	15	
16	<b>TOTAL Health Care and Programs</b>	2,473,080	194,588	840,966	3,508,634		3,508,634	50,621	3,559,255	16	
	<b>C. General Administration</b>										
17	Administrative	97,590		249,344	346,934		346,934	(236,518)	110,416	17	
18	Directors Fees									18	
19	Professional Services			166,129	166,129		166,129	86,457	252,586	19	
20	Dues, Fees, Subscriptions & Promotions			18,637	18,637		18,637	(1,421)	17,216	20	
21	Clerical & General Office Expenses	106,967	14,427	37,571	158,965		158,965	155,414	314,379	21	
22	Employee Benefits & Payroll Taxes			446,478	446,478		446,478		446,478	22	
23	Inservice Training & Education			150	150		150		150	23	
24	Travel and Seminar			330	330		330	6,334	6,664	24	
25	Other Admin. Staff Transportation			11,734	11,734		11,734	922	12,656	25	
26	Insurance-Prop.Liab.Malpractice			46,899	46,899		46,899	30,946	77,845	26	
27	Other (specify):* Allocated HO Benefits							14,668	14,668	27	
28	<b>TOTAL General Administration</b>	204,557	14,427	977,272	1,196,256		1,196,256	56,802	1,253,058	28	
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,118,922	521,561	2,145,305	5,785,788		5,785,788	70,774	5,856,562	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 E Peoria

#0049338

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	
	<b>D. Ownership</b>											
30	Depreciation			11,140	11,140		11,140	72,978	84,118			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,745	4,745		4,745	211,812	216,557			32
33	Real Estate Taxes			36,656	36,656		36,656	36,645	73,301			33
34	Rent-Facility & Grounds			1,008,355	1,008,355		1,008,355	(457,791)	550,564			34
35	Rent-Equipment & Vehicles			20,829	20,829		20,829	10,065	30,894			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,081,725	1,081,725		1,081,725	(126,291)	955,434			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		185,807		185,807		185,807		185,807			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			246,926	246,926		246,926		246,926			42
43	Other (specify):* See Att Sch 4A	75,515		316,517	392,032		392,032	(364,978)	27,054			43
44	<b>TOTAL Special Cost Centers</b>	75,515	185,807	563,443	824,765		824,765	(364,978)	459,787			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,194,437	707,368	3,790,473	7,692,278		7,692,278	(420,495)	7,271,783			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 E Peoria

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 1	Supplies 2	Other 3	Total 4					9	10
	Ancillary Expense										
	<b>E. Special Cost Centers</b>										
43	Other (specify):*				0		0		0		
	Laboratory Expense			21,804	21,804		21,804		21,804		
	Radiology Expenses			5,250	5,250		5,250		5,250		
	Non-Allowable Expenses	75,515		289,463	364,978		364,978	(364,978)	0		
					0		0		0		
					0		0		0		
	<b>TOTAL Other Special Cost Centers</b>	75,515	0	316,517	392,032	0	392,032	(364,978)	27,054		

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(10,694)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,916)	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	(28,163)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,737)	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	(520)	20		17
18	Fines and Penalties	(1,100)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,001)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(276,323)	43		24
25	Fund Raising, Advertising and Promotional	(3,492)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(484)	43		28
29	Other-Attach Schedule See Page 5A	(86,278)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (422,708)		\$	30

<b>BHF USE ONLY</b>						
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	
		<b>Amount</b>	<b>Reference</b>	
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)	2,213		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 2,213		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (420,495)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

Rosewood Care Ctr E Peoria

ID# 0049338

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	\$ (75,515)	43	1
2	Eliminate Lobbying & PAC Dues	(2,637)	20	2
3	Miscellaneous Income Offset	(1,271)	21	3
4	Disallow Resident Reimbursement	(148)	43	4
5	Disallow Marketing Mileage Reimbursement	(6,707)	25	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>		(86,278)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Ctr E Peoria# 0049338

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	1,688	0	0	0	0	0	0	0	0	1,688	1
2	Food Purchase	(12,431)	0	29	0	0	0	0	0	0	0	0	(12,402)	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	198	0	22	0	0	0	0	0	0	220	5
6	Maintenance	0	0	147	0	(30,813)	0	0	0	0	0	0	(30,666)	6
7	Other (specify):*	0	0	191	0	4,320	0	0	0	0	0	0	4,511	7
8	<b>TOTAL General Services</b>	<b>(12,431)</b>	<b>0</b>	<b>2,253</b>	<b>0</b>	<b>(26,471)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(36,649)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	42,389	4,296	0	0	0	0	0	0	0	0	46,685	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	3,451	485	0	0	0	0	0	0	0	0	3,936	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>45,840</b>	<b>4,781</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>50,621</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(123,654)	(112,864)	0	0	3,600	0	0	0	0	0	(232,918)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(6,001)	108	8,234	(18,863)	0	97,131	2,248	0	0	0	0	82,857	19
20	Fees, Subscriptions & Promotions	(3,157)	11	1,454	263	8	0	0	0	0	0	0	(1,421)	20
21	Clerical & General Office Expenses	(1,271)	48,413	93,240	12,753	663	439	1,177	0	0	0	0	155,414	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	1,713	2,813	105	1,640	63	0	0	0	0	0	6,334	24
25	Other Admin. Staff Transportation	(6,707)	2,589	1,215	256	3,569	0	0	0	0	0	0	922	25
26	Insurance-Prop.Liab.Malpractice	0	295	1,930	134	1,028	474	27,085	0	0	0	0	30,946	26
27	Other (specify):*	0	5,028	8,423	1,217	0	0	0	0	0	0	0	14,668	27
28	<b>TOTAL General Administration</b>	<b>(17,136)</b>	<b>(65,497)</b>	<b>4,445</b>	<b>(4,135)</b>	<b>6,908</b>	<b>98,107</b>	<b>34,110</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>56,802</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(29,567)</b>	<b>(19,657)</b>	<b>11,479</b>	<b>(4,135)</b>	<b>(19,563)</b>	<b>98,107</b>	<b>34,110</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>70,774</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Ctr E Peoria# 0049338

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)	
	<b>D. Ownership</b>													
30	Depreciation	0	0	6,460	0	1,108	0	65,410	0	0	0	0	72,978	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(28,163)	0	465	66	0	11,570	227,874	0	0	0	0	211,812	32
33	Real Estate Taxes	0	0	0	0	0	0	36,645	0	0	0	0	36,645	33
34	Rent-Facility & Grounds	0	0	5,809	0	0	0	(463,600)	0	0	0	0	(457,791)	34
35	Rent-Equipment & Vehicles	0	8,871	1,194	0	0	0	0	0	0	0	0	10,065	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(28,163)</b>	<b>8,871</b>	<b>13,928</b>	<b>66</b>	<b>1,108</b>	<b>11,570</b>	<b>(133,671)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(126,291)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(364,978)	0	0	0	0	0	0	0	0	0	0	(364,978)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(364,978)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(364,978)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(422,708)	(10,786)	25,407	(4,069)	(18,455)	109,677	(99,561)	0	0	0	0	(420,495)	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	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)	
1	V	10 Nursing & Medical Records	\$	Bravo Nursing Home Services, Inc.	0.00%	\$ 42,389	\$ 42,389	1
2	V	15 Mgmt. Allocation of Benefits		Bravo Nursing Home Services, Inc.	0.00%	3,451	3,451	2
3	V	17 Mgmt Fee/Administrative	138,000	Bravo Nursing Home Services, Inc.	0.00%	14,346	(123,654)	3
4	V	19 Professional Services		Bravo Nursing Home Services, Inc.	0.00%	108	108	4
5	V	20 Dues, Fees, Subs & Promotions		Bravo Nursing Home Services, Inc.	0.00%	11	11	5
6	V	21 Clerical and General Office		Bravo Nursing Home Services, Inc.	0.00%	48,413	48,413	6
7	V	24 Travel and Seminar		Bravo Nursing Home Services, Inc.	0.00%	1,713	1,713	7
8	V	25 Other Admin. Staff Transport.		Bravo Nursing Home Services, Inc.	0.00%	2,589	2,589	8
9	V	26 Insurance-Prop./Liab./Malprac.		Bravo Nursing Home Services, Inc.	0.00%	295	295	9
10	V	27 Mgmt. Allocation of Benefits		Bravo Nursing Home Services, Inc.	0.00%	5,028	5,028	10
11	V	35 Rent-Equipment & Vehicles		Bravo Nursing Home Services, Inc.	0.00%	8,871	8,871	11
12	V							12
13	V							13
14	Total		\$ 138,000			\$ 127,214	\$ * (10,786)	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	<u>1</u> Dietary	\$	Midwest Administrative Services, Inc.	0.00%	\$ 1,688	\$ 1,688
16	V	<u>2</u> Food		Midwest Administrative Services, Inc.	0.00%	29	29
17	V	<u>5</u> Utilities		Midwest Administrative Services, Inc.	0.00%	198	198
18	V	<u>6</u> Maintenance		Midwest Administrative Services, Inc.	0.00%	147	147
19	V	<u>7</u> Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	191	191
20	V	<u>10</u> Nursing and Medical Records		Midwest Administrative Services, Inc.	0.00%	4,296	4,296
21	V	<u>15</u> Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	485	485
22	V	<u>17</u> Mgmt Fee/Administrative	114,944	Midwest Administrative Services, Inc.	0.00%	2,080	(112,864)
23	V	<u>19</u> Professional Services		Midwest Administrative Services, Inc.	0.00%	8,234	8,234
24	V	<u>20</u> Dues, Fees, Subs & Promotions		Midwest Administrative Services, Inc.	0.00%	1,454	1,454
25	V	<u>21</u> Clerical and General Office		Midwest Administrative Services, Inc.	0.00%	93,240	93,240
26	V	<u>24</u> Travel and Seminar		Midwest Administrative Services, Inc.	0.00%	2,813	2,813
27	V	<u>25</u> Other Admin. Staff Transport.		Midwest Administrative Services, Inc.	0.00%	1,215	1,215
28	V	<u>26</u> Insurance-Prop./Liab./Malprac.		Midwest Administrative Services, Inc.	0.00%	1,930	1,930
29	V	<u>27</u> Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	8,423	8,423
30	V	<u>30</u> Depreciation		Midwest Administrative Services, Inc.	0.00%	6,460	6,460
31	V	<u>32</u> Interest		Midwest Administrative Services, Inc.	0.00%	465	465
32	V	<u>34</u> Rent-Facility and Grounds		Midwest Administrative Services, Inc.	0.00%	5,809	5,809
33	V	<u>35</u> Rent-Equipment & Vehicles		Midwest Administrative Services, Inc.	0.00%	1,194	1,194
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 114,944			\$ 140,351	\$ * 25,407

\* 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	\$ 19,484	Claims Administration Services, LLC	0.00%	\$ 621	\$ (18,863)
16	V	20 Dues, Fees, Subs & Promotions		Claims Administration Services, LLC	0.00%	263	263
17	V	21 Clerical and General Office		Claims Administration Services, LLC	0.00%	12,753	12,753
18	V	24 Travel and Seminar		Claims Administration Services, LLC	0.00%	105	105
19	V	25 Other Admin. Staff Transport.		Claims Administration Services, LLC	0.00%	256	256
20	V	26 Insurance-Prop./Liab./Malprac.		Claims Administration Services, LLC	0.00%	134	134
21	V	27 Mgmt. Allocation of Benefits		Claims Administration Services, LLC	0.00%	1,217	1,217
22	V	32 Interest		Claims Administration Services, LLC	0.00%	66	66
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		\$ 19,484			\$ 15,415	\$ * (4,069)

\* 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%	\$ 22	\$ 22	15
16	V	6 Maintenance	101,223	Senior Living Services, Inc.	0.00%	70,410	(30,813)	16
17	V	7 Mgmt. Allocation of Benefits		Senior Living Services, Inc.	0.00%	4,320	4,320	17
18	V	20 Dues, Fees, Subs & Promotions		Senior Living Services, Inc.	0.00%	8	8	18
19	V	21 Clerical and General Office		Senior Living Services, Inc.	0.00%	663	663	19
20	V	24 Travel and Seminar		Senior Living Services, Inc.	0.00%	1,640	1,640	20
21	V	25 Other Admin. Staff Transport.		Senior Living Services, Inc.	0.00%	3,569	3,569	21
22	V	26 Insurance-Prop./Liab./Malprac.		Senior Living Services, Inc.	0.00%	1,028	1,028	22
23	V	30 Depreciation		Senior Living Services, Inc.	0.00%	1,108	1,108	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		\$ 101,223			\$ 82,768	\$ * (18,455)	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%	\$ 97,131	\$	97,131	15
16	V	21 Clerical and General Office		Bravo Holding Company	0.00%	439		439	16
17	V	24 Travel and Seminar		Bravo Holding Company	0.00%	63		63	17
18	V	26 Insurance-Prop./Liab./Malprac.		Bravo Holding Company	0.00%	474		474	18
19	V	32 Interest	4,745	Bravo Holding Company	0.00%	16,315		11,570	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		\$ 4,745			\$ 114,422	\$ *	109,677	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	\$	East Peoria Real Estate, Inc.	0.00%	\$ 3,600	\$ 3,600
16	V	19 Professional Services		East Peoria Real Estate, Inc.	0.00%	2,248	2,248
17	V	21 Clerical and General Office		East Peoria Real Estate, Inc.	0.00%	1,177	1,177
18	V	26 Insurance-Prop./Liab./Malprac.		East Peoria Real Estate, Inc.	0.00%	27,085	27,085
19	V	30 Depreciation		East Peoria Real Estate, Inc.	0.00%	65,410	65,410
20	V	32 Interest		East Peoria Real Estate, Inc.	0.00%	227,874	227,874
21	V	33 Real Estate Taxes		East Peoria Real Estate, Inc.	0.00%	36,645	36,645
22	V	34 Rent-Facility and Grounds	463,600	East Peoria Real Estate, Inc.	0.00%		(463,600)
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		\$ 463,600			\$ 364,039	\$ * (99,561)

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

Facility Name & ID Number

Rosewood Care Ctr E Peoria

# 0049338

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 Alton, Inc.	Alton, IL	Bravo Care of Wood		Supportive Living	2
3			Bravo Care of Edwardsville, Inc.	Edwardsville, IL	River, Inc.	Wood River, IL	Facility	3
4			Bravo Care of Elgin, Inc.	Elgin, IL	Bravo Nursing Home			4
5			Bravo Care of Galeburg, Inc.	Galesburg, IL	Services, Inc.	St. Louis, MO	Management Co.	5
6			Bravo Care of Inverness, Inc.	Inverness, IL	Bravo Holding			6
7			Bravo Care of Joliet, Inc.	Joliet, IL	Company, Inc.	St. Louis, MO	Holding Co.	7
8			Bravo Care of Moline, Inc.	Moline, 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					East Peoria Real			14
15					Estate, Inc.	East Peoria, 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 E Peoria # 0049338 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	96,270	3.47	6.94	Salary	\$ 7,173	L17, C7	1
2	Mark Yampol	CEO (Note 2)	Administrative	0.00	27,922	3.47	6.94	Salary	2,080	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	\$ 9,253		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 E Peoria

# 0049338 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	34,486	\$ 42,389	1
2	15	Mgmt. Allocation of Benefits	WeightedCensus	497,328	15	49,766		34,486	3,451	2
3	17	Administrative	WeightedCensus	497,328	15	206,886	206,886	34,486	14,346	3
4	19	Professional Services	WeightedCensus	497,328	15	1,560		34,486	108	4
5	20	Dues, Fees, Subs & Promotions	WeightedCensus	497,328	15	155		34,486	11	5
6	21	Clerical and General Office	WeightedCensus	497,328	15	698,165	683,784	34,486	48,413	6
7	24	Travel and Seminar	WeightedCensus	497,328	15	24,702		34,486	1,713	7
8	25	Other Admin. Staff Transport.	WeightedCensus	497,328	15	37,333		34,486	2,589	8
9	26	Insurance-Prop./Liab./Malprac.	WeightedCensus	497,328	15	4,250		34,486	295	9
10	27	Mgmt. Allocation of Benefits	WeightedCensus	497,328	15	72,507		34,486	5,028	10
11	35	Rent-Equipment & Vehicles	WeightedCensus	497,328	15	127,935		34,486	8,871	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		\$ 127,214	25

Facility Name & ID Number Rosewood Care Ctr E Peoria

# 0049338 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	34,486	\$ 1,688	1	
2	2	Food	497,328	15	417		34,486	29	2	
3	5	Utilities	497,328	15	2,858		34,486	198	3	
4	6	Maintenance	497,328	15	2,125		34,486	147	4	
5	7	Mgmt. Allocation of Benefits	497,328	15	2,750		34,486	191	5	
6	10	Nursing and Medical Records	497,328	15	61,958	61,958	34,486	4,296	6	
7	15	Mgmt. Allocation of Benefits	497,328	15	6,997		34,486	485	7	
8	17	Administrative	497,328	15	30,003	30,003	34,486	2,080	8	
9	19	Professional Services	497,328	15	118,742		34,486	8,234	9	
10	20	Dues, Fees, Subs & Promotions	497,328	15	20,968		34,486	1,454	10	
11	21	Clerical and General Office	497,328	15	1,344,593	1,045,674	34,486	93,240	11	
12	24	Travel and Seminar	497,328	15	40,571		34,486	2,813	12	
13	25	Other Admin. Staff Transport.	497,328	15	17,516		34,486	1,215	13	
14	26	Insurance-Prop./Liab./Malprac.	497,328	15	27,838		34,486	1,930	14	
15	27	Mgmt. Allocation of Benefits	497,328	15	121,473		34,486	8,423	15	
16	30	Depreciation	497,328	15	93,160		34,486	6,460	16	
17	32	Interest	497,328	15	6,702		34,486	465	17	
18	34	Rent-Facility and Grounds	497,328	15	83,780		34,486	5,809	18	
19	35	Rent-Equipment & Vehicles	497,328	15	17,213		34,486	1,194	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		\$ 140,351	25

Facility Name & ID Number Rosewood Care Ctr E Peoria

# 0049338 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 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/Direct Exp 497,328	15	\$ 38,020	\$	34,486	\$ 621	1	
2	20	Dues, Fees, Subs & Promotions	Weighted Census 497,328	15	3,789		34,486	263	2	
3	21	Clerical and General Office	Weighted Census 497,328	15	183,917	183,869	34,486	12,753	3	
4	24	Travel and Seminar	Weighted Census 497,328	15	1,515		34,486	105	4	
5	25	Other Admin. Staff Transport.	Weighted Census 497,328	15	3,685		34,486	256	5	
6	26	Insurance-Prop./Liab./Malprac.	Weighted Census 497,328	15	1,930		34,486	134	6	
7	27	Mgmt. Allocation of Benefits	Weighted Census 497,328	15	17,550		34,486	1,217	7	
8	32	Interest	Weighted Census 497,328	15	957		34,486	66	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		\$ 15,415	25

Facility Name & ID Number Rosewood Care Ctr E Peoria

# 0049338 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5** Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
1	5	Utilities	WeightedCensus	497,328	15	\$ 320	\$ 34,486	\$ 22	1	
2	6	Maintenance	WeightedCensus/Direct Exp	497,328	15	998,295	573,323	34,486	70,410	2
3	7	Mgmt. Allocation of Benefits	WeightedCensus	497,328	15	62,296	34,486	34,486	4,320	3
4	20	Dues, Fees, Subs & Promotions	WeightedCensus	497,328	15	120	34,486	34,486	8	4
5	21	Clerical and General Office	WeightedCensus	497,328	15	9,566	34,486	34,486	663	5
6	24	Travel and Seminar	WeightedCensus	497,328	15	23,651	34,486	34,486	1,640	6
7	25	Other Admin. Staff Transport.	WeightedCensus	497,328	15	51,467	34,486	34,486	3,569	7
8	26	Insurance-Prop./Liab./Malprac.	WeightedCensus	497,328	15	14,825	34,486	34,486	1,028	8
9	30	Depreciation	WeightedCensus	497,328	15	15,975	34,486	34,486	1,108	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								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					\$ 1,176,515	\$ 573,323	\$	82,768	25

Facility Name & ID Number Rosewood Care Ctr E Peoria

# 0049338

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	\$ 34,486	\$ 97,131	1
2	21	Clerical and General Office	Weighted Census	497,328	15	6,337	34,486	439	2
3	24	Travel and Seminar	Weighted Census	497,328	15	913	34,486	63	3
4	26	Insurance-Prop./Liab./Malprac.	Weighted Census	497,328	15	6,835	34,486	474	4
5	32	Interest	Weighted Census	497,328	15	235,278	34,486	16,315	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	\$	\$ 114,422	25

Facility Name &amp; ID Number

Rosewood Care Ctr E Peoria

# 0049338

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	Name of Lender	2		3	4	5	6		8	9	10	Reporting Period Interest Expense				
		Related**					Monthly Payment Required	Date of Note					Amount of Note		Maturity Date	Interest Rate (4 Digits)
		YES	NO										Original	Balance		
	<b>A. Directly Facility Related</b>															
	<b>Long-Term</b>															
1	Berkadia		X	Mortgage	\$70,396.80	10/1/03	\$ 10,665,100	\$ 9,087,405	11/1/38	0.0496	\$ 226,350	1				
2												2				
3												3				
4												4				
5												5				
	<b>Working Capital</b>															
6	MidCap (Thru Allocation of		X	Revolving Line of Credit		8/1/09			12/31/14	5.0000	16,315	6				
7	Bravo Holding Co.)											7				
8												8				
9	<b>TOTAL Facility Related</b>				\$70,396.80		\$ 10,665,100	\$ 9,087,405			\$ 242,665	9				
	<b>B. Non-Facility Related*</b>															
10							Less: Interest Income Offset				(28,188)	10				
11							Amortization Expense				1,549	11				
12							Allocated from Mgmt Co's				531	12				
13												13				
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (26,108)	14				
15	<b>TOTALS (line 9+line14)</b>						\$ 10,665,100	\$ 9,087,405			\$ 216,557	15				

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 23,204 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.)

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>																								
1. Real Estate Tax accrual used on 2013 report.				\$	72,594	1																				
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	See Below			\$	72,108	2																				
3. Under or (over) accrual (line 2 minus line 1).				\$	(486)	3																				
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	73,787	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>				\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>				\$		6																				
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	73,301	7																				
Real Estate Tax History:																										
Real Estate Tax Bill for Calendar Year:	2009	64,686	8	<b>FOR BHF USE ONLY</b> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%;"></td> <td style="width: 75%;">FROM R. E. TAX STATEMENT FOR 2013</td> <td style="width: 10%; text-align: right;">\$</td> <td style="width: 10%;"></td> </tr> <tr> <td>13</td> <td></td> <td></td> <td style="text-align: center;">13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">16</td> </tr> </table>				FROM R. E. TAX STATEMENT FOR 2013	\$		13			13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
	FROM R. E. TAX STATEMENT FOR 2013	\$																								
13			13																							
14	PLUS APPEAL COST FROM LINE 5	\$	14																							
15	LESS REFUND FROM LINE 6	\$	15																							
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																							
Taxes Paid-2012	2010	66,234	9																							
Taxes Paid-2013	2011	65,673	10																							
Total Taxes Paid	2012	71,875	11																							
	2013	72,340	12																							
<u>Accrual based on prior year tax bill.</u>																										
<u>Note: The real estate entity was purchased on 12/31/13, therefore the beginning accrual used above reflects the accrued real estate tax balance as of 6/30/13 in order for the worksheet to compute properly.</u>																										
<u>See explanation on Att Sch I</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.**



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

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

C. **Tax Bills**

Attach a copy of the original 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: 39,125 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>301,000</u>	<u>1988</u>	<u>\$ 64,385</u>	1
2					2
3	<b>TOTALS</b>	<b>301,000</b>		<b>\$ 64,385</b>	3

**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	1989	1989	\$ 2,961,197	\$		\$ 37,015	\$ 37,015	\$ 1,869,256	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Building Improvements - Real Estate Entity									9
10										10
11	Improvements-Original Construction		1989	209,624		25	3,494	3,494	209,624	11
12	Generator		1989	14,937		10			14,937	12
13	Signs		1989	3,157		10			3,157	13
14	Walk-in Cooler		1989	5,770		10			5,770	14
15	Sinks		1989	3,744		10			3,744	15
16	Exhaust Hood		1989	4,621		10			4,621	16
17	Fire System		1989	1,271		10			1,271	17
18	Carpeting		1989	10,368		10			10,368	18
19	Cubicle Track		1989	6,294		10			6,294	19
20	Fence		1990	2,377		25	48	48	2,258	20
21	Concrete Work		1991	5,190		25	104	104	4,775	21
22	Door Installation		1991	2,750		10			2,750	22
23	Painting		1992	7,694						23
24	Sprinkler Addition		1992	786		10			786	24
25	Irrigation System		1993	10,175		25	204	204	8,581	25
26	Ceramic Sink		1994	2,011		10			2,011	26
27	Parking Lot Extension		2003	37,488		25	750	750	15,995	27
28	Shingle Roof Replacement		2004	97,105		40				28
29	Door Closures		2005	2,870		10	144	144	2,463	29
30	Patient Room Sinks		2006	12,035		10	602	602	9,983	30
31	Heat Pumps		2006	28,515		10	1,427	1,427	23,526	31
32	2 Copper Exchange Boilers		2006	4,400		10	220	220	3,373	32
33	Seal & Stripe Parking Lot		2006	3,275		25	66	66	1,026	33
34	Cooling Towers		2007	47,061		10	2,353	2,353	33,727	34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number Rosewood Care Ctr E Peoria

# 0049338

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>Generator Replacement/Upgrade</u>	2008	11,915		10	394	394	7,498	39
40	<u>Water Piping</u>	2008	3,583		10	179	179	2,478	40
41	<u>Heat Pumps</u>	2008	2,885		10	145	145	1,851	41
42	<u>Parking Lot Light Fixtures</u>	2008	3,125		10	157	157	1,979	42
43	<u>Water Softener</u>	2008	7,643		10	382	382	4,522	43
44	<u>Condensor HVAC</u>	2008	4,800		10	240	240	2,720	44
45	<u>Seal &amp; Stripe Parking Lot</u>	2008	3,895		25	78	78	935	45
46	<u>Telephone System</u>	2008	16,974		10	849	849	10,326	46
47	<u>Emergency Power System Generator</u>	2009	29,688		10	1,485	1,485	15,834	47
48	<u>New Counter Tops</u>	2009	4,347		10	218	218	2,246	48
49	<u>Mcquay Heat Pumps</u>	2009	37,963		10	1,898	1,898	17,716	49
50	<u>Boiler</u>	2009	3,250		10	163	163	1,517	50
51	<u>Carpet</u>	2010	10,123		10	506	506	4,427	51
52	<u>Water Heater</u>	2010	3,990		10	200	200	1,762	52
53	<u>Doors</u>	2010	1,275		10	64	64	531	53
54	<u>Sealcoat Parking Lot</u>	2010	4,255		25	85	85	681	54
55	<u>Sprinkler</u>	2012	20,131		40	252	252	797	55
56	<u>Curb Sidewalk Concrete</u>	2012	13,086		25	262	262	960	56
57	<u>Water Filtration System</u>	2013	4,147		40	52	52	130	57
58	<u>Replace Sidewalk and Repair Dumpster</u>	2013	2,640		40	33	33	72	58
59	<u>Windows and Screens</u>	2013	2,755		40	35	35	75	59
60	<u>Sprinkler</u>	2013	17,352		40	181	181	361	60
61	<u>Door Replacement</u>	2013	21,726		40	204	204	407	61
62	<u>Grease Trap</u>	2013	7,080		40	59	59	118	62
63	<u>Parking Lot Expansion</u>	2013	4,550		25	74	74	147	63
64	<u>HVAC Improvements</u>	2014	51,737		10	1,224	1,224	2,447	64
65	<u>Water Softener</u>	2014	5,033		10	42	42	84	65
66	<u>Cooling Tower</u>	2014	3,136		10	13	13	26	66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 3,787,799	\$		\$ 55,901	\$ 55,901	\$ 2,322,943	70

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

Facility Name & ID Number Rosewood Care Ctr E Peoria

# 0049338

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		\$ 3,787,799	\$		\$ 55,901	\$ 55,901	\$ 2,322,943	1
2	Leasehold Improvements - Operating Entity								2
3									3
4	Boiler Expansion Tank & Pressure Gauge	2008	3,450	493	7	493		2,793	4
5	Carpet For Lounge & Dining Room	2009	3,691	527	7	527		2,636	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)		\$ 3,794,940	\$ 1,020		\$ 56,921	\$ 55,901	\$ 2,328,372	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	\$ 47,291	\$ 9,266	\$ 9,266	\$	5	\$ 14,453	71
72	Current Year Purchases	5,712	854	854			854	72
73	Fully Depreciated Assets							73
74	Allocated from Mgmt Co/Real Estate Entity	838,552		17,077	17,077		797,050	74
75	TOTALS	\$ 891,555	\$ 10,120	\$ 27,197	\$ 17,077		\$ 812,357	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)	\$ 4,750,880	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 11,140	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 84,118	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 72,978	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,140,729	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.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: East 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>550,564</u>	<u>5</u>	<u>Unlimited</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		120		\$ 550,564			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.

N/A

This amount was calculated by dividing the total amount to be amortized

by the length of the lease N/A.

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

**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: \$ 22,754 Description: Offsite Storage- \$983, Medical Equipment- \$21,771, Home Office Allocation - \$10,065

(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>Patient</u>	<u>2012 Ford E350 Van</u>	\$ <u>678.33</u>	\$ <u>8,140</u>	17
18					18
19					19
20					20
21	TOTAL		\$ 678.33	\$ 8,140	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 E Peoria # 0049338 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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	<b>TOTALS</b>	\$	\$	\$	\$
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**

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

- (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	\$	9,042	\$ 345,027	\$	9,042	\$ 345,027	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,653	75,268		1,653	75,268	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		9,947	380,510	2,344	9,947	382,854	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				185,807		185,807	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	<b>TOTAL</b>			\$	20,642	\$ 800,805	\$ 188,151	20,642	\$ 988,956	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 E Peoria

# 0049338

Report 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*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 9,679	\$ 53,558	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>271,622</u> )	1,253,628	1,253,628	3
4	Supply Inventory (priced at <u>Cost</u> )	3,735	3,735	4
5	Short-Term Investments			5
6	Prepaid Insurance	14,532	16,921	6
7	Other Prepaid Expenses	3,434	3,434	7
8	Accounts Receivable (owners or related parties)	509,991	510,117	8
9	Other(specify): <u>R.E. tax refund &amp; insurance ded</u>	3,771	3,771	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,798,770	\$ 1,845,164	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		64,385	13
14	Buildings, at Historical Cost		2,961,197	14
15	Leasehold Improvements, at Historical Cost	7,141	833,743	15
16	Equipment, at Historical Cost	53,003	891,555	16
17	Accumulated Depreciation (book methods)	(20,736)	(3,140,729)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		152,525	21
22	Other Long-Term Assets (spec <u>Loan Fees</u> )		166,257	22
23	Other(specify): <u>Deposits</u>	2,000	2,000	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 41,408	\$ 1,930,933	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,840,178	\$ 3,776,097	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 546,779	\$ 574,783	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	241,382	241,382	30
31	Accrued Taxes Payable (excluding real estate taxes)	34,082	34,082	31
32	Accrued Real Estate Taxes(Sch.IX-B)		73,787	32
33	Accrued Interest Payable		41,554	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	8,885	24,155	35
<b>Other Current Liabilities(specify):</b>				
36	<u>Accrued Expenses</u>	238,876	249,576	36
37	<u>Accrued Rent</u>	431,365		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,501,369	\$ 1,239,319	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,087,405	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 9,087,405	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,501,369	\$ 10,326,724	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 338,809	\$ (6,550,627)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,840,178	\$ 3,776,097	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 276,271	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 276,272	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	62,537	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)	\$ 62,537	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 338,809	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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 9,315,293	1
2	Discounts and Allowances for all Levels	(1,974,720)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 7,340,573</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	299,125	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 299,125</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
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	7,664	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	70,852	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 80,916</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	28,163	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 28,163</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Attached Schedule</u>	6,038	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 6,038</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 7,754,815</b>	<b>30</b>

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,080,898	31
32	Health Care	3,508,634	32
33	General Administration	1,196,256	33
<b>B. Capital Expense</b>			
34	Ownership	1,081,725	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	577,839	35
36	Provider Participation Fee	246,926	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 7,692,278</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>62,537</b>	<b>41</b>
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 62,537</b>	<b>43</b>

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,837,086	44
45	Private Pay - Net Inpatient Revenue	2,555,883	45
46	Medicare - Net Inpatient Revenue	2,318,686	46
47	Other-(specify) <u>Insurance</u>	628,918	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 7,340,573</b>	<b>49</b>

\* 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 E Peoria

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

Schedule 19A

Other Revenue:

Vending Income	3,030
Vendor Discount	1,737
Miscellaneous	1,271
	<hr/>
Total Other Revenue	<u>6,038</u>

Facility Name & ID Number Rosewood Care Ctr E Peoria

# 0049338

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	2,080	2,260	\$ 62,701	\$ 27.74	1
2	Assistant Director of Nursing	1,921	1,978	51,383	25.98	2
3	Registered Nurses	14,995	15,574	409,939	26.32	3
4	Licensed Practical Nurses	27,942	29,854	590,456	19.78	4
5	CNAs & Orderlies	90,609	95,590	1,012,117	10.59	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,962	2,093	22,926	10.95	8
9	Activity Director	1,779	2,112	19,458	9.21	9
10	Activity Assistants	3,507	3,693	31,910	8.64	10
11	Social Service Workers	3,865	4,025	49,316	12.25	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,813	24,010	216,007	9.00	15
16	Dishwashers					16
17	Maintenance Workers	2,295	2,458	31,011	12.62	17
18	Housekeepers	16,442	17,179	144,651	8.42	18
19	Laundry	5,048	5,272	49,616	9.41	19
20	Administrator	2,128	2,276	97,590	42.88	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,379	9,049	106,967	11.82	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,036	3,353	33,860	10.10	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Sch 20A</u>	13,919	15,107	264,529	17.51	33
34	TOTAL (lines 1 - 33)	222,720	235,883	\$ 3,194,437 *	\$ 13.54	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	\$ 7,950	L1, C3	35
36	Medical Director	Monthly	18,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,222	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	2,400	L11, C3	44
45	Social Service Consultant	Monthly	2,400	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 38,972		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 E Peoria

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	2,335	2,479	56,315	22.72
Case Manager	3,060	3,339	48,716	14.59
Rehabilitation Nurse	2,081	2,265	42,449	18.74
Ward Clerk	2,224	2,328	41,534	17.84
Marketing	4,219	4,696	75,515	16.08
<b>TOTAL</b>	<u>13,919</u>	<u>15,107</u>	<u>264,529</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	
Becky Woiwode	Administrator	0	\$ 97,590	Workers' Compensation Insurance	\$ 85,566	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	85,493	Advertising: Employee Recruitment	2,788	
				FICA Taxes	240,117	Health Care Worker Background Check (Indicate # of checks performed)	3,669	
				Employee Health Insurance	28,151	Patient Background Checks		
				Employee Meals		Misc. Dues/Subscriptions/Fees	1,020	
				Illinois Municipal Retirement Fund (IMRF)*		Rosewood License Fee	1,500	
				Employee Relations	2,426	IHCA Dues	4,232	
				Employee Uniforms	1,710	Misc. Licenses & Fees	801	
				Employee Physicals	2,399	Home Office Allocation	1,736	
				Employee Drug Tests	616	Less: Public Relations Expense	(520)	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
\$ 97,590				\$ 446,478			\$ 17,216	
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
Mgmt Fees-Bravo Nursing Home Svc-See Page 6, Elimon P 3, C 7			\$ 138,000	N/A			Out-of-State Travel	\$
Mgmt Fees-Midwest Admin Svc-See Page 6, Elimon P 3, C 7 from 1/1/14-6/30/14 (post-acquisition)			111,344				In-State Travel	
							Home Office Allocation	6,334
							Seminar Expense	330
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			Entertainment Expense (agree to Sch. V, line 24, col. 8)	
\$ 249,344				\$			\$ 6,664	
C. Professional Services								
Vendor/Payee	Type	Amount						
Hochschild, Bloom & Company	Accountant/Consultant	\$ 3,394						
Midwest Administrative Services	Administrative/Bookkeeping	114,734						
Claims Administration Services, Inc.	Related Party Legal Fees	19,484						
Advantage Reporting Svc	Transcript Fees	949						
CJ Schlosser & Co.	Accountant/Consultant	100						
Cusack, Gilfillan and O'Day	Legal Fees	50						
Daniel Maher	Legal Fees	8,609						
Healthcare Horizons	Healthcare Consulting	1,135						
Henry Simmons Jr. M.D.	Medical Record Review	3,010						
Livingston Barger	Legal Fees	1,571						
Quinn, Johnston, Henderson & Pret	Legal Fees	5,190						
See Attached Schedule		7,903						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)								
\$ 166,129								

\* Attach copy of IMRF notifications

\*\*See instructions.

Rosewood Care Ctr E Peoria

Period Beginning  
Period End

07/01/2013  
06/30/2014

Schedule 21A

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Reynolds Reporting Svcs	Transcript fees	203
Senior Care Capital	Closing Fees	7,500
US Managed Care Services, LLC	Managed Care Network	200
	<b>Total</b>	<b>7,903</b>

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	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Rosewood Care Ctr E Peoria# 0049338Report 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. \$ 54,174 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. \$ 246,926  
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. \$ 10,694
- (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.