

Facility Name & ID Number Rosewood Care Ctr of Peoria

0049312 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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	12,926	8,914	4,604	26,444	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,926	8,914	4,604	26,444	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.37%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

NO

Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

NO

I. On what date did you start providing long term care at this location?

Date started 12/1/07

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

YES

Date 12/1/07

NO

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

YES

NO

If YES, enter number of beds certified 52 and days of care provided 3,334

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: 6/30/2015 Fiscal Year: 6/30/2015

* 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:

07/01/2014

Ending:

06/30/2015

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	241,186	32,148	8,599	281,933		281,933	3,516	285,449		1
2	Food Purchase		192,435		192,435		192,435	(9,981)	182,454		2
3	Housekeeping	17,247	9,954	162,483	189,684		189,684		189,684		3
4	Laundry	5,364	12,934	108,322	126,620		126,620		126,620		4
5	Heat and Other Utilities			127,560	127,560		127,560	352	127,912		5
6	Maintenance	41,786	11,207	231,541	284,534		284,534	(46,949)	237,585		6
7	Other (specify):* Allocated HO Benefits							3,754	3,754		7
8	TOTAL General Services	305,583	258,678	638,505	1,202,766		1,202,766	(49,308)	1,153,458		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	1,514,343	151,532	311,813	1,977,688		1,977,688	39,521	2,017,209		10
10a	Therapy		2,280	698,710	700,990		700,990		700,990		10a
11	Activities	77,651	2,741	2,400	82,792		82,792		82,792		11
12	Social Services	34,812		2,400	37,212		37,212		37,212		12
13	CNA Training										13
14	Program Transportation			2,440	2,440		2,440		2,440		14
15	Other (specify):* Allocated HO Benefits							4,193	4,193		15
16	TOTAL Health Care and Programs	1,626,806	156,553	1,035,763	2,819,122		2,819,122	43,714	2,862,836		16
	C. General Administration										
17	Administrative	65,966		303,896	369,862		369,862	(258,334)	111,528		17
18	Directors Fees										18
19	Professional Services			136,239	136,239		136,239	107,272	243,511		19
20	Dues, Fees, Subscriptions & Promotions			10,959	10,959		10,959	4,583	15,542		20
21	Clerical & General Office Expenses	90,164	18,110	129,754	238,028		238,028	127,543	365,571		21
22	Employee Benefits & Payroll Taxes			298,659	298,659		298,659		298,659		22
23	Inservice Training & Education			488	488		488		488		23
24	Travel and Seminar			229	229		229	7,942	8,171		24
25	Other Admin. Staff Transportation			8,572	8,572		8,572	1,785	10,357		25
26	Insurance-Prop.Liab.Malpractice			57,490	57,490		57,490	12,619	70,109		26
27	Other (specify):* Allocated HO Benefits							20,226	20,226		27
28	TOTAL General Administration	156,130	18,110	946,286	1,120,526		1,120,526	23,636	1,144,162		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,088,519	433,341	2,620,554	5,142,414		5,142,414	18,042	5,160,456		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: 07/01/2014 Ending: 06/30/2015

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			15,448	15,448	15,448	136,945	152,393				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			21,388	21,388	21,388	293,163	314,551				32
33	Real Estate Taxes						99,871	99,871				33
34	Rent-Facility & Grounds			1,051,979	1,051,979	1,051,979	(1,042,467)	9,512				34
35	Rent-Equipment & Vehicles			20,691	20,691	20,691	(6,473)	14,218				35
36	Other (specify):* Mortgage Ins.						26,774	26,774				36
37	TOTAL Ownership			1,109,506	1,109,506	1,109,506	(492,187)	617,319				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		127,502		127,502	127,502		127,502				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			211,939	211,939	211,939		211,939				42
43	Other (specify):* See Att Sch 4A	82,662		80,486	163,148	163,148	(141,186)	21,962				43
44	TOTAL Special Cost Centers	82,662	127,502	292,425	502,589	502,589	(141,186)	361,403				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,171,181	560,843	4,022,485	6,754,509	6,754,509	(615,331)	6,139,178				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

Rosewood Care Ctr of Peoria

Period Beginning 07/01/2014

Period End 06/30/2015

Schedule 4A

V. Cost Center Expenses

		Cost Per General Ledger				Reclass- ification	Reclassified Total	Adjust- ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					5	6
		1	2	3	4						
	Ancillary Expense										
	E. Special Cost Centers										
43	Other (specify):*				0		0		0		
	Laboratory/OP Expenses			15,233	15,233		15,233		15,233		
	Radiology Expenses			6,729	6,729		6,729		6,729		
	Non-Allowable Expenses	82,662		58,524	141,186		141,186	(141,186)	0		
					0		0		0		
					0		0		0		
	TOTAL Other Special Cost Centers	82,662	0	80,486	163,148	0	163,148	(141,186)	21,962		

Facility Name & ID Number Rosewood Care Ctr of Peoria

0049312

Report Period Beginning: 07/01/2014

Ending: 06/30/2015

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	(7,378)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,503)	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	(32,292)	32		10
11	Discounts, Allowances, Rebates & Refunds	(2,604)	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				17
18	Fines and Penalties	(1,323)	43		18
19	Entertainment	(12)	43		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,031)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(47,312)	43		24
25	Fund Raising, Advertising and Promotional	(4,058)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(507)	43		28
29	Other-Attach Schedule See Page 5A	(104,154)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (205,174)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(410,157)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (410,157)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (615,331)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Care Ctr of Peoria

ID# 0049312

Report Period Beginning: 07/01/2014

Ending: 06/30/2015

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Eliminate Marketing Salary	\$ (82,662)	43	1
2	Eliminate Lobbying & PAC Dues	(1,318)	20	2
3	Miscellaneous Income Offset	161	21	3
4	Resident Reimbursements	(809)	43	4
5	Management Fee-Real Estate Entity	(7,200)	17	5
6	Related Party Auto Lease	(8,160)	35	6
7	Mileage Reimbursement Related to Marketing	(4,166)	25	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		(104,154)	49

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	1 Dietary	\$	Bravo Nursing Home Services, Inc.	0.00%	\$ 632	\$ 632	1
2	V	6 Maintenance		Bravo Nursing Home Services, Inc.	0.00%	22	22	2
3	V	7 Mgmt. Allocation of Benefits		Bravo Nursing Home Services, Inc.	0.00%	67	67	3
4	V	10 Nursing & Medical Records		Bravo Nursing Home Services, Inc.	0.00%	31,602	31,602	4
5	V	15 Mgmt. Allocation of Benefits		Bravo Nursing Home Services, Inc.	0.00%	3,357	3,357	5
6	V	17 Administrative	138,000	Bravo Nursing Home Services, Inc.	0.00%	11,485	(126,515)	6
7	V	19 Professional Services		Bravo Nursing Home Services, Inc.	0.00%	89	89	7
8	V	20 Dues, Fees, Subs & Promotions		Bravo Nursing Home Services, Inc.	0.00%	44	44	8
9	V	21 Clerical and General Office		Bravo Nursing Home Services, Inc.	0.00%	38,183	38,183	9
10	V	24 Travel and Seminar		Bravo Nursing Home Services, Inc.	0.00%	1,712	1,712	10
11	V	25 Other Admin. Staff Transport.		Bravo Nursing Home Services, Inc.	0.00%	1,512	1,512	11
12	V	26 Insurance-Prop./Liab./Malprac.		Bravo Nursing Home Services, Inc.	0.00%	165	165	12
13	V	27 Mgmt. Allocation of Benefits		Bravo Nursing Home Services, Inc.	0.00%	5,174	5,174	13
14	Total		\$ 138,000			\$ 94,044	\$ * (43,956)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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%	\$ 2,884	\$	2,884	15
16	V	<u>2</u> Food		Midwest Administrative Services, Inc.	0.00%	1		1	16
17	V	<u>5</u> Utilities		Midwest Administrative Services, Inc.	0.00%	114		114	17
18	V	<u>6</u> Maintenance		Midwest Administrative Services, Inc.	0.00%	874		874	18
19	V	<u>7</u> Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	304		304	19
20	V	<u>10</u> Nursing and Medical Records		Midwest Administrative Services, Inc.	0.00%	7,919		7,919	20
21	V	<u>15</u> Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	836		836	21
22	V	<u>17</u> Administrative	165,896	Midwest Administrative Services, Inc.	0.00%	34,077		(131,819)	22
23	V	<u>19</u> Professional Services		Midwest Administrative Services, Inc.	0.00%	6,062		6,062	23
24	V	<u>20</u> Dues, Fees, Subs & Promotions		Midwest Administrative Services, Inc.	0.00%	5,676		5,676	24
25	V	<u>21</u> Clerical and General Office	61,107	Midwest Administrative Services, Inc.	0.00%	125,575		64,468	25
26	V	<u>24</u> Travel and Seminar		Midwest Administrative Services, Inc.	0.00%	2,652		2,652	26
27	V	<u>25</u> Other Admin. Staff Transport.		Midwest Administrative Services, Inc.	0.00%	1,509		1,509	27
28	V	<u>26</u> Insurance-Prop./Liab./Malprac.		Midwest Administrative Services, Inc.	0.00%	3,052		3,052	28
29	V	<u>27</u> Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	13,664		13,664	29
30	V	<u>30</u> Depreciation		Midwest Administrative Services, Inc.	0.00%	12,806		12,806	30
31	V	<u>32</u> Interest		Midwest Administrative Services, Inc.	0.00%	10,207		10,207	31
32	V	<u>34</u> Rent-Facility and Grounds		Midwest Administrative Services, Inc.	0.00%	9,512		9,512	32
33	V	<u>35</u> Rent-Equipment & Vehicles		Midwest Administrative Services, Inc.	0.00%	1,687		1,687	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 227,003			\$ 239,411	\$ *	12,408	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 38,020	Claims Administration Services, LLC	0.00%	\$ 224	\$ (37,796)
16	V	21 Clerical and General Office		Claims Administration Services, LLC	0.00%	12,915	12,915
17	V	24 Travel and Seminar		Claims Administration Services, LLC	0.00%	744	744
18	V	25 Other Admin. Staff Transport.		Claims Administration Services, LLC	0.00%	390	390
19	V	26 Insurance-Prop./Liab./Malprac.		Claims Administration Services, LLC	0.00%	165	165
20	V	27 Mgmt. Allocation of Benefits		Claims Administration Services, LLC	0.00%	1,388	1,388
21	V						
22	V						
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		\$ 38,020			\$ 15,826	\$ * (22,194)

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

SEE ACCOUNTANTS' COMPILATION REPORT

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%	\$ 238	\$ 238
16	V	6 Maintenance	77,968	Senior Living Services, Inc.	0.00%	30,123	(47,845)
17	V	7 Mgmt. Allocation of Benefits		Senior Living Services, Inc.	0.00%	3,383	3,383
18	V	19 Professional Services		Senior Living Services, Inc.	0.00%	7	7
19	V	21 Clerical and General Office		Senior Living Services, Inc.	0.00%	582	582
20	V	24 Travel and Seminar		Senior Living Services, Inc.	0.00%	2,610	2,610
21	V	25 Other Admin. Staff Transport.		Senior Living Services, Inc.	0.00%	2,310	2,310
22	V	26 Insurance-Prop./Liab./Malprac.		Senior Living Services, Inc.	0.00%	681	681
23	V	30 Depreciation		Senior Living Services, Inc.	0.00%	937	937
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		\$ 77,968			\$ 40,871	\$ * (37,097)

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

SEE ACCOUNTANTS' COMPILATION REPORT

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%	\$ 133,851	\$	133,851	15
16	V	20 Fees & Subscriptions		Bravo Holding Company	0.00%	51		51	16
17	V	21 Clerical and General Office		Bravo Holding Company	0.00%	684		684	17
18	V	24 Travel and Seminar		Bravo Holding Company	0.00%	224		224	18
19	V	25 Other Admin. Staff Transport.		Bravo Holding Company	0.00%	230		230	19
20	V	26 Insurance-Prop./Liab./Malprac.		Bravo Holding Company	0.00%	547		547	20
21	V	32 Interest		Bravo Holding Company	0.00%	14,389		14,389	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		\$			\$ 149,976	\$ *	149,976	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$	Peoria Real Estate, Inc.	0.00%	\$ 7,200	\$ 7,200
16	V	19 Professional Services		Peoria Real Estate, Inc.	0.00%	6,090	6,090
17	V	20 Dues & Subscriptions		Peoria Real Estate, Inc.	0.00%	130	130
18	V	21 Clerical and General Office		Peoria Real Estate, Inc.	0.00%	10,550	10,550
19	V	26 Insurance-Prop./Liab./Malprac.		Peoria Real Estate, Inc.	0.00%	8,009	8,009
20	V	30 Depreciation		Peoria Real Estate, Inc.	0.00%	123,202	123,202
21	V	32 Interest	22	Peoria Real Estate, Inc.	0.00%	300,881	300,859
22	V	33 Real Estate Taxes		Peoria Real Estate, Inc.	0.00%	99,871	99,871
23	V	34 Rent-Facility and Grounds	1,051,979	Peoria Real Estate, Inc.	0.00%		(1,051,979)
24	V	36 Mortgage Insurance		Peoria Real Estate, Inc.	0.00%	26,774	26,774
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		\$ 1,052,001			\$ 582,707	\$ * (469,294)

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 East Peoria, Inc.	East Peoria, IL	River, Inc.	Wood River, IL	Facility	3
4			Bravo Care of Edwardsville, Inc.	Edwardsville, IL	Bravo Nursing Home			4
5			Bravo Care of Elgin, Inc.	Elgin, IL	Services, Inc.	St. Louis, MO	Management Co.	5
6			Bravo Care of Galeburg, Inc.	Galesburg, IL	Bravo Holding			6
7			Bravo Care of Inverness, Inc.	Inverness, IL	Company, Inc.	St. Louis, MO	Holding Co.	7
8			Bravo Care of Joliet, Inc.	Joliet, IL	Senior Living		Building Services	8
9			Bravo Care of Moline, Inc.	Moline, IL	Services, Inc.	St. Louis, MO	Company	9
10			Bravo Care of Northbrook, Inc.	Northbrook, 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	St. Louis, MO		13
14					Peoria Real Estate,			14
15					Inc.	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Peoria # 0049312 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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	Mark Yampol	CEO	Administrative	0.00	57,561	4.97	9.94	Salary	3,429	L17, C7	1
2	Mark Yampol	CEO	Administrative	0.00	1,415,656	See Above	See Above	Consulting	84,344	L19, C7	2
3	Hillel Yampol	Owner	Administrative	0.00	45,431	4.97	9.94	Salary	2,707	L17, C7	3
4	Christene Rene Yampol	Owner	Administrative	0.00	67,961	4.97	9.94	Salary	4,049	L17, C7	4
5											5
6	See Attached Schedule 7A										6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 94,529		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: 07/01/2014

Ending: 6/30/2015

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	1	Dietary	470,290	14	11,239	11,239	26,444	\$ 632	1
2	6	Maintenance	470,290	14	397		26,444	22	2
3	7	Mgmt. Allocation of Benefits	470,290	14	1,193		26,444	67	3
4	10	Nursing & Medical Records	470,290	14	562,016	562,016	26,444	31,602	4
5	15	Mgmt. Allocation of Benefits	470,290	14	59,699		26,444	3,357	5
6	17	Administrative	470,290	14	204,253	204,253	26,444	11,485	6
7	19	Professional Services	470,290	14	1,579		26,444	89	7
8	20	Dues, Fees, Subs & Promotions	470,290	14	786		26,444	44	8
9	21	Clerical and General Office	470,290	14	679,056	662,076	26,444	38,183	9
10	24	Travel and Seminar	470,290	14	30,438		26,444	1,712	10
11	25	Other Admin. Staff Transport.	470,290	14	26,889		26,444	1,512	11
12	26	Insurance-Prop./Liab./Malprac.	470,290	14	2,943		26,444	165	12
13	27	Mgmt. Allocation of Benefits	470,290	14	92,023		26,444	5,174	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				\$ 1,672,511	\$ 1,439,584		\$ 94,044	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Peoria

0049312 Report Period Beginning: 07/01/2014

Ending: 6/30/2015

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	Weighted Census	470,290	14	51,283	51,283	26,444	\$ 2,884	1
2	2	Food	Weighted Census	470,290	14	13		26,444	1	2
3	5	Utilities	Weighted Census	470,290	14	2,032		26,444	114	3
4	6	Maintenance	Weighted Census	470,290	14	15,554		26,444	874	4
5	7	Mgmt. Allocation of Benefits	Weighted Census	470,290	14	5,409		26,444	304	5
6	10	Nursing and Medical Records	Weighted Census	470,290	14	140,839	140,839	26,444	7,919	6
7	15	Mgmt. Allocation of Benefits	Weighted Census	470,290	14	14,860		26,444	836	7
8	17	Administrative	Weighted Census	470,290	14	606,045	606,045	26,444	34,077	8
9	19	Professional Services	Weighted Census	470,290	14	107,816		26,444	6,062	9
10	20	Dues, Fees, Subs & Promotions	Weighted Census	470,290	14	100,942		26,444	5,676	10
11	21	Clerical and General Office	Weighted Census	470,290	14	2,233,257	1,697,067	26,444	125,575	11
12	24	Travel and Seminar	Weighted Census	470,290	14	47,164		26,444	2,652	12
13	25	Other Admin. Staff Transport.	Weighted Census	470,290	14	26,845		26,444	1,509	13
14	26	Insurance-Prop./Liab./Malprac.	Weighted Census	470,290	14	54,274		26,444	3,052	14
15	27	Mgmt. Allocation of Benefits	Weighted Census	470,290	14	243,011		26,444	13,664	15
16	30	Depreciation	Weighted Census	470,290	14	227,745		26,444	12,806	16
17	32	Interest	Weighted Census	470,290	14	181,530		26,444	10,207	17
18	34	Rent-Facility and Grounds	Weighted Census	470,290	14	169,173		26,444	9,512	18
19	35	Rent-Equipment & Vehicles	Weighted Census	470,290	14	30,003		26,444	1,687	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 4,257,795	\$ 2,495,234		\$ 239,411	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Peoria

0049312 Report Period Beginning: 07/01/2014

Ending: 6/30/2015

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Professional Services	Weighted Census	470,290	14	3,980	26,444	\$ 224	1
2	21	Clerical and General Office	Weighted Census	470,290	14	229,689	226,926	12,915	2
3	24	Travel and Seminar	Weighted Census	470,290	14	13,239	26,444	744	3
4	25	Other Admin. Staff Transport.	Weighted Census	470,290	14	6,938	26,444	390	4
5	26	Insurance-Prop./Liab./Malprac.	Weighted Census	470,290	14	2,943	26,444	165	5
6	27	Mgmt. Allocation of Benefits	Weighted Census	470,290	14	24,684	26,444	1,388	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 281,473	\$ 226,926		\$ 15,826	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Peoria

0049312 Report Period Beginning: 07/01/2014

Ending: 6/30/2015

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	Utilities	Weighted Census	470,290	14	4,237	26,444	\$ 238	1	
2	6	Maintenance	Weighted Census/Direct Exp	470,290	14	513,005	471,253	26,444	30,123	2
3	7	Mgmt. Allocation of Benefits	Weighted Census	470,290	14	60,169	26,444	26,444	3,383	3
4	19	Professional Services	Weighted Census	470,290	14	123	26,444	26,444	7	4
5	21	Clerical and General Office	Weighted Census	470,290	14	10,353	26,444	26,444	582	5
6	24	Travel and Seminar	Weighted Census	470,290	14	46,417	26,444	26,444	2,610	6
7	25	Other Admin. Staff Transport.	Weighted Census	470,290	14	41,082	26,444	26,444	2,310	7
8	26	Insurance-Prop./Liab./Malprac.	Weighted Census	470,290	14	12,112	26,444	26,444	681	8
9	30	Depreciation	Weighted Census	470,290	14	16,668	26,444	26,444	937	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 704,166	\$ 471,253	\$	40,871	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Peoria

0049312 Report Period Beginning: 07/01/2014

Ending: 6/30/2015

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Professional Services	Weighted Census	470,290	14	2,380,463	26,444	\$ 133,851	1
2	20	Fees & Subscriptions	Weighted Census	470,290	14	901	26,444	51	2
3	21	Clerical and General Office	Weighted Census	470,290	14	12,160	26,444	684	3
4	24	Travel and Seminar	Weighted Census	470,290	14	3,989	26,444	224	4
5	25	Other Admin. Staff Transport.	Weighted Census	470,290	14	4,094	26,444	230	5
6	26	Insurance-Prop./Liab./Malprac.	Weighted Census	470,290	14	9,723	26,444	547	6
7	32	Interest	Weighted Census	470,290	14	255,901	26,444	14,389	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,667,231	\$	\$ 149,976	25

SEE ACCOUNTANTS' COMPILATION REPORT

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	11						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	Berkadia		X	Mortgage	\$82,647.82	11/1/06	\$ 12,422,200	\$ 11,176,078	12/1/41	0.0525	\$ 294,806	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	MidCap (Thru Allocation of		X	Revolving Line of Credit		8/1/09			12/31/15	5.0000	21,388	6						
7	Bravo Holding Co.)											7						
8												8						
9	TOTAL Facility Related				\$82,647.82		\$ 12,422,200	\$ 11,176,078			\$ 316,194	9						
B. Non-Facility Related*																		
10							Less: Interest Income Offset				(32,314)	10						
11							Amortization Expense				6,075	11						
12							Allocated from Mgmt Co's				24,596	12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			(1,643)	14						
15	TOTALS (line 9+line14)						\$ 12,422,200	\$ 11,176,078			\$ 314,551	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 26,774 Line # 36

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

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.)

2014 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 Mary Offner
 TELEPHONE (314) 994-9070 FAX #: (314) 994-9912

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2014 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 2014.

(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>96,491.20</u>	\$ <u>96,491.20</u>
2. <u>14-17-326-010</u>	<u>SW 1/4 SEC 17-9N-8E</u>	\$ <u>1,791.36</u>	\$ <u>1,791.36</u>
3. <u>14-17-376-001</u>	<u>SW 1/4 SEC 17-9-8E</u>	\$ <u>802.70</u>	\$ <u>802.70</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>99,085.26</u></u>	\$ <u><u>99,085.26</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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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:

07/01/2014 Ending:

06/30/2015

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: 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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>	<u>7.343 Acres</u>	<u>1989</u>	<u>\$ 874,484</u>	1
2					2
3	TOTALS	#VALUE!		\$ 874,484	3

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	
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	\$ 2,851,771	\$		\$ 70,267	\$ 70,267	\$ 1,832,808
5									
6									
7									
8									
Improvement Type**									
9	Building Improvements - Real Estate Entity								
10									
11	Legal, Architect, Engineering, Contractor Fees		1989	32,140					32,140
12	Capitalized Interest		1989	15,100		25			15,100
13	Site Improvements, Sewers, Landscaping, Traffic Study		1989	306,686		25			306,686
14	Walk-in Cooler		1989	5,770		10			5,770
15	Sinks		1989	3,744		10			3,744
16	Exhaust Hood		1989	4,620		10			4,620
17	Fire Suppression System		1989	1,271		10			1,271
18	Generator		1989	14,937		10			14,937
19	Intercom System		1989	650		10			650
20	Facility Signs		1989	3,234		10			3,234
21	Baseboard Heater		1989	672		10			672
22	Carpet		1989	7,664		10			7,664
23	Cubicle Track		1989	6,294		10			6,294
24	Entry Concrete Slab		1990	6,197		25	248	248	5,908
25	Roof Valley		1991	4,140		40	104	104	2,476
26	Sign		1991	3,733		10			3,733
27	Monument Sign		1992	1,737		10			1,737
28	Irrigation System		1993	10,125		25	405	405	8,944
29	Parking Lot Expansion		1994	3,475		25	139	139	2,896
30	Ceramic Sink		1994	2,011		10			2,011
31	Parking Lot Expansion		1995	56,648		25	2,266	2,266	44,374
32	Irrigation System		1995	2,029		25	81	81	1,589
33	Parking Lot		1997	39,664		25	1,587	1,587	29,352
34									
35									
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

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

Report Period Beginning:

07/01/2014

Ending:

06/30/2015**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>Parking Lot Sealing & Striping</u>	2004	21,277		25	851	851	9,858	39
40	<u>Backflow Preventers</u>	2005	6,600		10	440	440	6,600	40
41	<u>Roof</u>	2005	89,412		40	2,235	2,235	21,980	41
42	<u>Door Closers</u>	2005	2,870		10	287	287	2,750	42
43	<u>Console Heat Pumps</u>	2006	6,337		10	634	634	5,915	43
44	<u>Heat Pumps</u>	2007	3,320		10	332	332	2,573	44
45	<u>Cooling Tower</u>	2008	50,686		10	5,069	5,069	35,903	45
46	<u>Cooling Unit for Walk-In Cooler</u>	2008	3,700		10	370	370	2,621	46
47	<u>Seal and Stripe Parking Lot</u>	2008	6,490		25	260	260	1,818	47
48	<u>Cabinet/Countertops</u>	2009	4,347		10	435	435	2,681	48
49	<u>Telephone System</u>	2009	30,716		10	3,072	3,072	18,942	49
50	<u>Generator</u>	2009	4,781		10	478	478	2,829	50
51	<u>Sprinkler Pipe</u>	2010	2,928		10	293	293	1,562	51
52	<u>Asphalt Parking Lot</u>	2010	61,200		25	2,448	2,448	12,036	52
53	<u>Sidewalks</u>	2010	7,200		25	288	288	1,440	53
54	<u>Water Heater</u>	2011	3,016		10	302	302	1,207	54
55	<u>Doors</u>	2011	19,324		10	1,932	1,932	7,407	55
56	<u>Replace Boiler</u>	2012	7,842		10	784	784	2,734	56
57	<u>Sprinkler</u>	2012	3,830		10	383	383	1,213	57
58	<u>Sidewalks</u>	2012	5,239		25	210	210	577	58
59	<u>Tuckpointing</u>	2012	4,482		40	112	112	317	59
60	<u>Shower Renovation - new flooring, new Az Rock wall system,</u>	2012	45,215		40	1,130	1,130	3,108	60
61	<u>new shower heads, handles & drains</u>								61
62	<u>Water Filtration System</u>	2013	3,997		40	100	100	225	62
63	<u>HVAC Unit</u>	2013	5,257		40	131	131	295	63
64	<u>Sprinkler</u>	2012	16,874		40	421	421	1,234	64
65	<u>New HVAC Unit</u>	2013	3,760		40	94	94	180	65
66	<u>Door</u>	2013	3,300		40	83	83	145	66
67	<u>Grease Trap</u>	2013	6,293		40	157	157	249	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,814,605	\$		\$ 98,428	\$ 98,428	\$ 2,487,009	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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		\$ 3,814,605	\$		\$ 98,428	\$ 98,428	\$ 2,487,009	1
2	Building Improvements - Real Estate Entity, continued								2
3									3
4									4
5									5
6	Boiler Pump	2013	2,700		10	270	270	540	6
7	Cooling Tower	2013	2,639		10	264	264	286	7
8	Fire Alarm Panel	2014	4,995		10	500	500	542	8
9	Sprinkler	2014	4,287		40	107	107	125	9
10	Seal Coating	2014	6,325		25	211	211	211	10
11	Repair Dry Pendant	2015	4,173		40	35	35	35	11
12	Install Console Units-Rm 404, 406, 407, 408, 409, 410, 411, 412, and	2015	9,515		10	476	476	476	12
13	Update Fire Alarm System-400 Wing	2015	5,750		10	144	144	144	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)		\$ 3,854,989	\$		\$ 100,435	\$ 100,435	\$ 2,489,368	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,854,989	\$		\$ 100,435	\$ 100,435	\$ 2,489,368	1
2	Leasehold Improvements - Operating Entity								2
3									3
4	Firestopping	2013	3,285	657	5	657		1,369	4
5	Install Flooring Rm 404, 406, 407, 408, 409, 410, 411, and 412	2014	21,155	1,762	7	1,762		1,762	5
6	Install Wallpaper Rm 404, 406, 407, 408, 409, 410, 411, and 412	2014	4,300	358	7	358		358	6
7	Kitchen Imp-sink base, repair wall, cove base, Installed new cabin	2014	4,430	369	7	369		369	7
8	cabinet base, counter top and sink. Replaced plumbing								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)		\$ 3,888,159	\$ 3,146		\$ 103,581	\$ 100,435	\$ 2,493,226	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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	\$ 61,501	\$ 12,302	\$ 12,302	\$	5	\$ 29,698	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Allocated from Mgmt Co/Real Estate Entity	920,044		36,510	36,510		871,643	74
75	TOTALS	\$ 981,545	\$ 12,302	\$ 48,812	\$ 36,510		\$ 901,341	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	N/A									77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,744,188	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 15,448	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 152,393	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 136,945	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,394,567	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		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: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Allocated from Mgmt Co's				9,512			6
7	TOTAL				\$ 9,512			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. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

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

by the length of the lease N/A.

N/A

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

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 14,218 Description: Offsite Storage - \$2,205, Medical Equipment - \$10,326, Home Office Allocation - \$1,687

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Ctr of Peoria # 0049312 Report Period Beginning: 07/01/2014 Ending: 06/30/2015
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- 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		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	8,354	\$ 300,750	\$	8,354	\$ 300,750	1	
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,756	80,765		1,756	80,765	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		7,552	317,195	2,280	7,552	319,475	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				127,502		127,502	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify):									13	
14	TOTAL			\$	17,662	\$ 698,710	\$ 129,782	17,662	\$ 828,492	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: 07/01/2014

Ending: 06/30/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2015 (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	\$ (21,964)	\$ (21,466)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>305,000</u>)	986,544	986,544	3
4	Supply Inventory (priced at <u>Cost</u>)	3,966	3,966	4
5	Short-Term Investments			5
6	Prepaid Insurance	25,858	29,226	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	789,146	789,146	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,783,550	\$ 1,787,416	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		874,484	13
14	Buildings, at Historical Cost		2,855,944	14
15	Leasehold Improvements, at Historical Cost	29,885	1,032,215	15
16	Equipment, at Historical Cost	64,786	981,545	16
17	Accumulated Depreciation (book methods)	(33,556)	(3,394,567)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		81,938	21
22	Other Long-Term Assets (spec <u>Loan Fees</u>)		236,293	22
23	Other(specify): <u>Deposits</u>	2,000	2,000	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 63,115	\$ 2,669,852	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,846,665	\$ 4,457,268	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 714,828	\$ 720,470	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	101,887	101,887	30
31	Accrued Taxes Payable (excluding real estate taxes)	33,240	33,240	31
32	Accrued Real Estate Taxes(Sch.IX-B)		101,243	32
33	Accrued Interest Payable		7,763	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	10,512	32,322	35
Other Current Liabilities(specify):				
36	<u>Accrued Expenses</u>	496,901	508,101	36
37	<u>Accrued Rent</u>	1,007,929	(200)	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,365,297	\$ 1,504,826	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,176,078	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 11,176,078	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,365,297	\$ 12,680,904	46
47	TOTAL EQUITY(page 18, line 24)	\$ (518,632)	\$ (8,223,636)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,846,665	\$ 4,457,268	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 298,133	1
2	Restatements (describe):		2
3	Prior period post closing adjustments	7,356	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 305,489	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(824,121)	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)	\$ (824,121)	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)	\$ (518,632)	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	\$ 6,908,285	1
2	Discounts and Allowances for all Levels	(1,448,339)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,459,946	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	388,449	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 388,449	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	5,886	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	38,680	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 45,766	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	32,292	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 32,292	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached Schedule 19A	3,935	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,935	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,930,388	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,202,766	31
32	Health Care	2,819,122	32
33	General Administration	1,120,526	33
B. Capital Expense			
34	Ownership	1,109,506	34
C. Ancillary Expense			
35	Special Cost Centers	290,650	35
36	Provider Participation Fee	211,939	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,754,509	40
41	Income before Income Taxes (line 30 minus line 40)**	(824,121)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (824,121)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,698,420	44
45	Private Pay - Net Inpatient Revenue	1,899,780	45
46	Medicare - Net Inpatient Revenue	1,482,494	46
47	Other-(specify) <u>Insurance/Managed Care</u>	379,252	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,459,946	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

Rosewood Care Ctr of Peoria

Period Beginning 07/01/2014
Period End 06/30/2015

Schedule 19A

Other Revenue:

Vending Income	1,492
Vendor Discount	2,604
Miscellaneous	(161)
	<hr/>
Total Other Revenue	<u>3,935</u>

Facility Name & ID Number Rosewood Care Ctr of Peoria

0049312

Report Period Beginning: 07/01/2014

Ending: 06/30/2015

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	1,123	1,338	\$ 40,009	\$ 29.90	1
2	Assistant Director of Nursing	1,248	1,289	31,784	24.66	2
3	Registered Nurses	7,305	7,797	191,374	24.54	3
4	Licensed Practical Nurses	15,747	16,837	334,490	19.87	4
5	CNAs & Orderlies	62,192	65,845	683,664	10.38	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,022	2,247	21,445	9.54	8
9	Activity Director	2,191	2,607	40,008	15.35	9
10	Activity Assistants	3,959	4,223	37,643	8.91	10
11	Social Service Workers	3,122	3,278	34,812	10.62	11
12	Dietician					12
13	Food Service Supervisor	2,206	2,468	44,669	18.10	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,259	21,517	196,517	9.13	15
16	Dishwashers					16
17	Maintenance Workers	2,345	2,569	41,786	16.27	17
18	Housekeepers	1,068	1,613	17,247	10.69	18
19	Laundry	420	601	5,364	8.93	19
20	Administrator	2,160	2,208	65,966	29.88	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,766	9,315	90,164	9.68	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,849	3,066	30,264	9.87	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Sch 20A</u>	11,700	12,464	263,975	21.18	33
34	TOTAL (lines 1 - 33)	150,682	161,282	\$ 2,171,181 *	\$ 13.46	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 8,599	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	7,017	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)		\$ 38,416		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,640	\$ 59,843	L10, C3	50
51	Licensed Practical Nurses	6,355	218,623	L10, C3	51
52	Certified Nurse Assistants/Aides	1,073	20,704	L10, C3	52
53	TOTAL (lines 50 - 52)	9,068	\$ 299,170		53

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Care Ctr of Peoria

Period Beginning 07/01/2014
Period End 06/30/2015

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	2,160	2,218	61,432	27.70
Case Manager	1,516	1,599	40,649	25.42
Rehabilitation Nurse	1,853	1,982	38,339	19.34
Ward Clerk	2,019	2,290	40,893	17.86
Marketing	4,152	4,375	82,662	18.89
TOTAL	<u>11,700</u>	<u>12,464</u>	<u>263,975</u>	

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												
3	N/A											
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: 07/01/2014

Ending: 06/30/2015

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. 2,117 IHCA
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 42,715 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. \$ 211,939
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? 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. \$ 7,378
- (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.