FOR BHF USE

LL1

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0049312

Facility Name: Rosewood Care Ctr of Peoria

Address: 1500 W Northmoor Rd (Number) Peoria (City) 61614 (Zip Code)

County: Peoria

Telephone Number: (309)691-2200 **Fax #** (309)691-1548

HFS ID Number:

Date of Initial License for Current Owners: 12/1/07

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Larry Templin **Telephone Number:** (630) 361-2868
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2013 to 06/30/2014 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

Paid Preparer
(Signed) (Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, P.O. Box 9, Dunlap, IL 61525
(Telephone) (630) 361-2868 Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Rosewood Care Ctr of Peoria # 0049312 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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1	2,530	6,576	9,107	8
9	SNF/PED					9
10	ICF	12,324	10,069		22,393	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,325	12,599	6,576	31,500	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.92%

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 [X] 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 [X]

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 [X] Date 12/1/07 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 52 and days of care provided 5,286

Medicare Intermediary Novitas Solutions, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

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

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

Facility Name & ID Number Rosewood Care Ctr of Peoria # 0049312 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	236,750	26,713	6,410	269,873		269,873	1,542	271,415			1
2	Food Purchase		206,087		206,087		206,087	(13,580)	192,507			2
3	Housekeeping	148,010	33,470		181,480		181,480		181,480			3
4	Laundry	42,529	21,037		63,566		63,566		63,566			4
5	Heat and Other Utilities			128,849	128,849		128,849	201	129,050			5
6	Maintenance	41,269	12,407	193,770	247,446		247,446	(27,498)	219,948			6
7	Other (specify):* Allocated HO Benefits							4,120	4,120			7
8	**TOTAL General Services**	468,558	299,714	329,029	1,097,301		1,097,301	(35,215)	1,062,086			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,944,540	178,657	34,081	2,157,278		2,157,278	42,643	2,199,921			10
10a	Therapy		2,985	910,106	913,091		913,091		913,091			10a
11	Activities	74,595	3,444	2,600	80,639		80,639		80,639			11
12	Social Services	42,241		2,400	44,641		44,641		44,641			12
13	CNA Training											13
14	Program Transportation			3,456	3,456		3,456		3,456			14
15	Other (specify):* Allocated HO Benefits							3,595	3,595			15
16	**TOTAL Health Care and Programs**	2,061,376	185,086	970,643	3,217,105		3,217,105	46,238	3,263,343			16
	C. General Administration											
17	Administrative	72,318		239,101	311,419		311,419	(224,097)	87,322			17
18	Directors Fees											18
19	Professional Services			147,061	147,061		147,061	91,021	238,082			19
20	Dues, Fees, Subscriptions & Promotions			28,366	28,366		28,366	(1,051)	27,315			20
21	Clerical & General Office Expenses	90,687	13,025	34,796	138,508		138,508	143,072	281,580			21
22	Employee Benefits & Payroll Taxes			388,932	388,932		388,932		388,932			22
23	Inservice Training & Education											23
24	Travel and Seminar			275	275		275	5,787	6,062			24
25	Other Admin. Staff Transportation			9,158	9,158		9,158	3,147	12,305			25
26	Insurance-Prop.Liab.Malpractice			54,379	54,379		54,379	36,056	90,435			26
27	Other (specify):* Allocated HO Benefits							13,398	13,398			27
28	**TOTAL General Administration**	163,005	13,025	902,068	1,078,098		1,078,098	67,333	1,145,431			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,692,939	497,825	2,201,740	5,392,504		5,392,504	78,356	5,470,860			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Rosewood Care Ctr of Peoria #0049312 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			12,504	12,504		12,504	76,276	88,780			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,486	2,486		2,486	292,912	295,398			32
33	Real Estate Taxes			49,921	49,921		49,921	48,986	98,907			33
34	Rent-Facility & Grounds			1,130,236	1,130,236		1,130,236	(509,975)	620,261			34
35	Rent-Equipment & Vehicles			34,491	34,491		34,491	9,193	43,684			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,229,638	1,229,638		1,229,638	(82,608)	1,147,030			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		207,611		207,611		207,611		207,611			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			224,279	224,279		224,279		224,279			42
43	Other (specify):* See Schedule 4A	73,866		271,627	345,493		345,493	(322,354)	23,139			43
44	**TOTAL Special Cost Centers**	73,866	207,611	495,906	777,383		777,383	(322,354)	455,029			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,766,805	705,436	3,927,284	7,399,525		7,399,525	(326,606)	7,072,919			45

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

Rosewood Care Ctr of 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	5	6	7	8	9	10	
	Ancillary Expense											
	E. Special Cost Centers											
43	Other (specify):*				0		0		0			
	Laboratory Expense			17,414	17,414		17,414		17,414			
	Radiology Expenses			5,725	5,725		5,725		5,725			
	Non-Allowable Expenses	73,866		248,488	322,354		322,354	(322,354)	0			
					0		0		0			
					0		0		0			
	TOTAL Other Special Cost Centers	73,866	0	271,627	345,493	0	345,493	(322,354)	23,139			

Facility Name & ID Number Rosewood Care Ctr of Peoria # 0049312 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(11,804)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,041)	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	(20,223)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,802)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(2,637)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,938)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(241,591)	43		24
25	Fund Raising, Advertising and Promotional	(1,644)	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	(78,783)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (367,947)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	41,341		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 41,341		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (326,606)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		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

Rosewood Care Ctr of Peoria

ID# 0049312

Report Period Beginning: 07/01/2013

Ending: 06/30/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate Marketing Salary	$ (73,866)	43	1
2	Miscellaneous Income Offset	(369)	21	2
3	Disallow Resident Reimbursement	(728)	43	3
4	Disallow Marketing Mileage Reimbursement	(3,820)	25	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(78,783)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Ctr of Peoria **#** 0049312 **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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	1,542	0	0	0	0	0	0	0	0	1,542	1
2	Food Purchase	(13,606)	0	26	0	0	0	0	0	0	0	0	(13,580)	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	181	0	20	0	0	0	0	0	0	201	5
6	Maintenance	0	0	135	0	(27,633)	0	0	0	0	0	0	(27,498)	6
7	Other (specify):*	0	0	174	0	3,946	0	0	0	0	0	0	4,120	7
8	**TOTAL General Services**	(13,606)	0	2,058	0	(23,667)	0	0	0	0	0	0	(35,215)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	38,719	3,924	0	0	0	0	0	0	0	0	42,643	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	3,152	443	0	0	0	0	0	0	0	0	3,595	15
16	**TOTAL Health Care and Programs**	0	41,871	4,367	0	0	0	0	0	0	0	0	46,238	16
	C. General Administration													
17	Administrative	0	(124,896)	(102,801)	0	0	0	0	0	0	0	0	(227,697)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(4,938)	99	7,521	(2,630)	0	88,721	5,848	0	0	0	0	94,621	19
20	Fees, Subscriptions & Promotions	(2,637)	10	1,328	240	8	0	0	0	0	0	0	(1,051)	20
21	Clerical & General Office Expenses	(369)	44,221	85,165	11,649	606	401	1,399	0	0	0	0	143,072	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	1,565	2,570	96	1,498	58	0	0	0	0	0	5,787	24
25	Other Admin. Staff Transportation	(3,820)	2,365	1,109	233	3,260	0	0	0	0	0	0	3,147	25
26	Insurance-Prop.Liab.Malpractice	0	269	1,763	122	939	433	32,530	0	0	0	0	36,056	26
27	Other (specify):*	0	4,592	7,694	1,112	0	0	0	0	0	0	0	13,398	27
28	**TOTAL General Administration**	(11,764)	(71,775)	4,349	10,822	6,311	89,613	39,777	0	0	0	0	67,333	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(25,370)	(29,904)	10,774	10,822	(17,356)	89,613	39,777	0	0	0	0	78,356	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Ctr of Peoria # 0049312 **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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	5,901	0	1,012	0	69,363	0	0	0	0	76,276	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(20,223)	0	424	61	0	12,416	300,234	0	0	0	0	292,912	32
33	Real Estate Taxes	0	0	0	0	0	0	48,986	0	0	0	0	48,986	33
34	Rent-Facility & Grounds	0	0	5,306	0	0	0	(515,281)	0	0	0	0	(509,975)	34
35	Rent-Equipment & Vehicles	0	8,103	1,090	0	0	0	0	0	0	0	0	9,193	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(20,223)	8,103	12,721	61	1,012	12,416	(96,698)	0	0	0	0	(82,608)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(322,354)	0	0	0	0	0	0	0	0	0	0	(322,354)	43
44	TOTAL Special Cost Centers	(322,354)	0	0	0	0	0	0	0	0	0	0	(322,354)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(367,947)	(21,801)	23,495	10,883	(16,344)	102,029	(56,921)	0	0	0	0	(326,606)	45

Facility Name & ID Number Rosewood Care Ctr of Peoria # 0049312 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	Nursing & Medical Records	$	Bravo Nursing Home Services, Inc.	0.00%	$ 38,719	$ 38,719	1
2	V	15	Mgmt. Allocation of Benefits		Bravo Nursing Home Services, Inc.	0.00%	3,152	3,152	2
3	V	17	Mgmt Fee/Administrative	138,000	Bravo Nursing Home Services, Inc.	0.00%	13,104	(124,896)	3
4	V	19	Professional Services		Bravo Nursing Home Services, Inc.	0.00%	99	99	4
5	V	20	Dues, Fees, Subs & Promotions		Bravo Nursing Home Services, Inc.	0.00%	10	10	5
6	V	21	Clerical and General Office		Bravo Nursing Home Services, Inc.	0.00%	44,221	44,221	6
7	V	24	Travel and Seminar		Bravo Nursing Home Services, Inc.	0.00%	1,565	1,565	7
8	V	25	Other Admin. Staff Transport.		Bravo Nursing Home Services, Inc.	0.00%	2,365	2,365	8
9	V	26	Insurance-Prop./Liab./Malprac.		Bravo Nursing Home Services, Inc.	0.00%	269	269	9
10	V	27	Mgmt. Allocation of Benefits		Bravo Nursing Home Services, Inc.	0.00%	4,592	4,592	10
11	V	35	Rent-Equipment & Vehicles		Bravo Nursing Home Services, Inc.	0.00%	8,103	8,103	11
12	V								12
13	V								13
14	Total			$ 138,000			$ 116,199	$ * (21,801)	14

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

Facility Name & ID Number Rosewood Care Ctr of Peoria # 0049312 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Midwest Administrative Services, Inc.	0.00%	$ 1,542	$ 1,542	15
16	V	2	Food		Midwest Administrative Services, Inc.	0.00%	26	26	16
17	V	5	Utilities		Midwest Administrative Services, Inc.	0.00%	181	181	17
18	V	6	Maintenance		Midwest Administrative Services, Inc.	0.00%	135	135	18
19	V	7	Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	174	174	19
20	V	10	Nursing and Medical Records		Midwest Administrative Services, Inc.	0.00%	3,924	3,924	20
21	V	15	Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	443	443	21
22	V	17	Mgmt Fee/Administrative	104,701	Midwest Administrative Services, Inc.	0.00%	1,900	(102,801)	22
23	V	19	Professional Services		Midwest Administrative Services, Inc.	0.00%	7,521	7,521	23
24	V	20	Dues, Fees, Subs & Promotions		Midwest Administrative Services, Inc.	0.00%	1,328	1,328	24
25	V	21	Clerical and General Office		Midwest Administrative Services, Inc.	0.00%	85,165	85,165	25
26	V	24	Travel and Seminar		Midwest Administrative Services, Inc.	0.00%	2,570	2,570	26
27	V	25	Other Admin. Staff Transport.		Midwest Administrative Services, Inc.	0.00%	1,109	1,109	27
28	V	26	Insurance-Prop./Liab./Malprac.		Midwest Administrative Services, Inc.	0.00%	1,763	1,763	28
29	V	27	Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	7,694	7,694	29
30	V	30	Depreciation		Midwest Administrative Services, Inc.	0.00%	5,901	5,901	30
31	V	32	Interest		Midwest Administrative Services, Inc.	0.00%	424	424	31
32	V	34	Rent-Facility and Grounds		Midwest Administrative Services, Inc.	0.00%	5,306	5,306	32
33	V	35	Rent-Equipment & Vehicles		Midwest Administrative Services, Inc.	0.00%	1,090	1,090	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 104,701			$ 128,196	$ * 23,495	39

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

Facility Name & ID Number Rosewood Care Ctr of Peoria # 0049312 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Services	$ 3,197	Claims Administration Services, LLC	0.00%	$ 567	$ (2,630)	15
16	V	20	Dues, Fees, Subs & Promotions		Claims Administration Services, LLC	0.00%	240	240	16
17	V	21	Clerical and General Office		Claims Administration Services, LLC	0.00%	11,649	11,649	17
18	V	24	Travel and Seminar		Claims Administration Services, LLC	0.00%	96	96	18
19	V	25	Other Admin. Staff Transport.		Claims Administration Services, LLC	0.00%	233	233	19
20	V	26	Insurance-Prop./Liab./Malprac.		Claims Administration Services, LLC	0.00%	122	122	20
21	V	27	Mgmt. Allocation of Benefits		Claims Administration Services, LLC	0.00%	1,112	1,112	21
22	V	32	Interest		Claims Administration Services, LLC	0.00%	61	61	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			$ 3,197			$ 14,080	$ * 10,883	39

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

Facility Name & ID Number Rosewood Care Ctr of Peoria # 0049312 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	Senior Living Services, Inc.	0.00%	$ 20	$ 20	15
16	V	6	Maintenance	96,997	Senior Living Services, Inc.	0.00%	69,364	(27,633)	16
17	V	7	Mgmt. Allocation of Benefits		Senior Living Services, Inc.	0.00%	3,946	3,946	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%	606	606	19
20	V	24	Travel and Seminar		Senior Living Services, Inc.	0.00%	1,498	1,498	20
21	V	25	Other Admin. Staff Transport.		Senior Living Services, Inc.	0.00%	3,260	3,260	21
22	V	26	Insurance-Prop./Liab./Malprac.		Senior Living Services, Inc.	0.00%	939	939	22
23	V	30	Depreciation		Senior Living Services, Inc.	0.00%	1,012	1,012	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			$ 96,997			$ 80,653	$ * (16,344)	39

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

Facility Name & ID Number Rosewood Care Ctr of Peoria # 0049312 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Services	$	Bravo Holding Company	0.00%	$ 88,721	$ 88,721	15
16	V	21	Clerical and General Office		Bravo Holding Company	0.00%	401	401	16
17	V	24	Travel and Seminar		Bravo Holding Company	0.00%	58	58	17
18	V	26	Insurance-Prop./Liab./Malprac.		Bravo Holding Company	0.00%	433	433	18
19	V	32	Interest	2,486	Bravo Holding Company	0.00%	14,902	12,416	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			$ 2,486			$ 104,515	$ * 102,029	39

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

Facility Name & ID Number Rosewood Care Ctr of Peoria # 0049312 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Services	$	Peoria Real Estate, Inc.	0.00%	$ 5,848	$ 5,848	15
16	V	21	Clerical and General Office		Peoria Real Estate, Inc.	0.00%	1,399	1,399	16
17	V	26	Insurance-Prop./Liab./Malprac.		Peoria Real Estate, Inc.	0.00%	32,530	32,530	17
18	V	30	Depreciation		Peoria Real Estate, Inc.	0.00%	69,363	69,363	18
19	V	32	Interest		Peoria Real Estate, Inc.	0.00%	300,234	300,234	19
20	V	33	Real Estate Taxes		Peoria Real Estate, Inc.	0.00%	48,986	48,986	20
21	V	34	Rent-Facility and Grounds	515,281	Peoria Real Estate, Inc.	0.00%		(515,281)	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			$ 515,281			$ 458,360	$ * (56,921)	39

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

Facility Name & ID Number Rosewood Care Ctr of Peoria # 0049312 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 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								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Rosewood Care Ctr of Peoria # 0049312 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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Michael Brady	President (Note 1)	Administrative	0.00	96,891	3.17	6.34	Salary	$ 6,552	L17, C7	1
2	Mark Yampol	CEO (Note 2)	Administrative	0.00	28,102	3.17	6.34	Salary	1,900	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	$ 8,452		13

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

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

Facility Name & ID Number Rosewood Care Ctr of Peoria # 0049312 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 [X] NO [ ]

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

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

	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	31,500	$ 38,719	1
2	15	Mgmt. Allocation of Benefits	WeightedCensus	497,328	15	49,766		31,500	3,152	2
3	17	Administrative	WeightedCensus	497,328	15	206,886	206,886	31,500	13,104	3
4	19	Professional Services	WeightedCensus	497,328	15	1,560		31,500	99	4
5	20	Dues, Fees, Subs & Promotions	WeightedCensus	497,328	15	155		31,500	10	5
6	21	Clerical and General Office	WeightedCensus	497,328	15	698,165	683,784	31,500	44,221	6
7	24	Travel and Seminar	WeightedCensus	497,328	15	24,702		31,500	1,565	7
8	25	Other Admin. Staff Transport.	WeightedCensus	497,328	15	37,333		31,500	2,365	8
9	26	Insurance-Prop./Liab./Malprac.	WeightedCensus	497,328	15	4,250		31,500	269	9
10	27	Mgmt. Allocation of Benefits	WeightedCensus	497,328	15	72,507		31,500	4,592	10
11	35	Rent-Equipment & Vehicles	WeightedCensus	497,328	15	127,935		31,500	8,103	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		$ 116,199	25

Facility Name & ID Number Rosewood Care Ctr of Peoria # 0049312 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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5** Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	WeightedCensus	497,328	15	24,339	24,339	31,500	$ 1,542	1
2	2	Food	WeightedCensus	497,328	15	417		31,500	26	2
3	5	Utilities	WeightedCensus	497,328	15	2,858		31,500	181	3
4	6	Maintenance	WeightedCensus	497,328	15	2,125		31,500	135	4
5	7	Mgmt. Allocation of Benefits	WeightedCensus	497,328	15	2,750		31,500	174	5
6	10	Nursing and Medical Records	WeightedCensus	497,328	15	61,958	61,958	31,500	3,924	6
7	15	Mgmt. Allocation of Benefits	WeightedCensus	497,328	15	6,997		31,500	443	7
8	17	Administrative	WeightedCensus	497,328	15	30,003	30,003	31,500	1,900	8
9	19	Professional Services	WeightedCensus	497,328	15	118,742		31,500	7,521	9
10	20	Dues, Fees, Subs & Promotions	WeightedCensus	497,328	15	20,968		31,500	1,328	10
11	21	Clerical and General Office	WeightedCensus	497,328	15	1,344,593	1,045,674	31,500	85,165	11
12	24	Travel and Seminar	WeightedCensus	497,328	15	40,571		31,500	2,570	12
13	25	Other Admin. Staff Transport.	WeightedCensus	497,328	15	17,516		31,500	1,109	13
14	26	Insurance-Prop./Liab./Malprac.	WeightedCensus	497,328	15	27,838		31,500	1,763	14
15	27	Mgmt. Allocation of Benefits	WeightedCensus	497,328	15	121,473		31,500	7,694	15
16	30	Depreciation	WeightedCensus	497,328	15	93,160		31,500	5,901	16
17	32	Interest	WeightedCensus	497,328	15	6,702		31,500	424	17
18	34	Rent-Facility and Grounds	WeightedCensus	497,328	15	83,780		31,500	5,306	18
19	35	Rent-Equipment & Vehicles	WeightedCensus	497,328	15	17,213		31,500	1,090	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					$ 2,024,003	$ 1,161,974		$ 128,196	25

Facility Name & ID Number Rosewood Care Ctr of Peoria # 0049312 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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5** Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional Services	WeightedCensus/Direct Exp	497,328	15	$ 38,020	$	31,500	$ 567	1
2	20	Dues, Fees, Subs & Promotions	WeightedCensus	497,328	15	3,789		31,500	240	2
3	21	Clerical and General Office	WeightedCensus	497,328	15	183,917	183,869	31,500	11,649	3
4	24	Travel and Seminar	WeightedCensus	497,328	15	1,515		31,500	96	4
5	25	Other Admin. Staff Transport.	WeightedCensus	497,328	15	3,685		31,500	233	5
6	26	Insurance-Prop./Liab./Malprac.	WeightedCensus	497,328	15	1,930		31,500	122	6
7	27	Mgmt. Allocation of Benefits	WeightedCensus	497,328	15	17,550		31,500	1,112	7
8	32	Interest	WeightedCensus	497,328	15	957		31,500	61	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								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					$ 251,363	$ 183,869		$ 14,080	25

Facility Name & ID Number Rosewood Care Ctr of Peoria # 0049312 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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5** Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	WeightedCensus	497,328	15	$ 320	$	31,500	$ 20	1
2	6	Maintenance	WeightedCensus/Direct Exp	497,328	15	998,295	573,323	31,500	69,364	2
3	7	Mgmt. Allocation of Benefits	WeightedCensus	497,328	15	62,296		31,500	3,946	3
4	20	Dues, Fees, Subs & Promotions	WeightedCensus	497,328	15	120		31,500	8	4
5	21	Clerical and General Office	WeightedCensus	497,328	15	9,566		31,500	606	5
6	24	Travel and Seminar	WeightedCensus	497,328	15	23,651		31,500	1,498	6
7	25	Other Admin. Staff Transport.	WeightedCensus	497,328	15	51,467		31,500	3,260	7
8	26	Insurance-Prop./Liab./Malprac.	WeightedCensus	497,328	15	14,825		31,500	939	8
9	30	Depreciation	WeightedCensus	497,328	15	15,975		31,500	1,012	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		$ 80,653	25

Facility Name & ID Number Rosewood Care Ctr of Peoria # 0049312 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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5** Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional Services	WeightedCensus	497,328	15	$ 1,400,742	$	31,500	$ 88,721	1
2	21	Clerical and General Office	WeightedCensus	497,328	15	6,337		31,500	401	2
3	24	Travel and Seminar	WeightedCensus	497,328	15	913		31,500	58	3
4	26	Insurance-Prop./Liab./Malprac.	WeightedCensus	497,328	15	6,835		31,500	433	4
5	32	Interest	WeightedCensus	497,328	15	235,278		31,500	14,902	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								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					$ 1,650,105	$		$ 104,515	25

Facility Name & ID Number Rosewood Care Ctr of Peoria # 0049312 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Berkadia		X	Mortgage	$82,647.82	11/1/06	$ 12,422,200	$ 11,284,715	12/1/41	0.0525	$ 297,219	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MidCap (Thru Allocation of		X	Revolving Line of Credit		8/1/09			12/31/14	5.0000	14,902	6
7	Bravo Holding Co.)											7
8												8
9	TOTAL Facility Related				$82,647.82		$ 12,422,200	$ 11,284,715			$ 312,121	9
	B. Non-Facility Related*											
10							Less: Interest Income Offset				(20,245)	10
11							Amortization Expense				3,037	11
12							Allocated from Mgmt Co's				485	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (16,723)	14
15	TOTALS (line 9+line14)						$ 12,422,200	$ 11,284,715			$ 295,398	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 28,639 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.)**

Facility Name & ID Number Rosewood Care Ctr of Peoria # 0049312 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 98,861	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	$ 97,897	2
3. Under or (over) accrual (line 2 minus line 1).		$ (964)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 99,871	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 98,907	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:				
		2009	96,584	8
Taxes Paid-2012	48,956	2010	97,909	9
Taxes Paid-2013	48,941	2011	98,592	10
Total Taxes Paid	97,897	2012	97,884	11
		2013	95,340	12

Accrual based on prior year tax bill.

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. See explanation on Att Sch I

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-17-326-009	1500 W. Northmoor Road	$ 95,339.52	$ 95,339.52
2.	14-17-326-010	SW 1/4 SEC 17-9N-8E	$ 1,769.98	$ 1,769.98
3.	14-17-376-001	SW 1/4 SEC 17-9-8E	$ 803.14	$ 803.14
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 97,912.64	$ 97,912.64

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Rosewood Care Ctr of Peoria # 0049312 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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 [X] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	7.343 Acres	1989	$ 874,484	1
2					2
3	TOTALS	#VALUE!		$ 874,484	3

Facility Name & ID Number Rosewood Care Ctr of Peoria # 0049312 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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		1989	1989	$ 2,851,771	$		$ 35,134	$ 35,134	$ 1,762,541	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements - Real Estate Entity										9
10											10
11	Legal, Architect, Engineering, Contractor Fees			1989	32,140			643	643	32,140	11
12	Capitalized Interest			1989	15,100		25	302	302	15,100	12
13	Site Improvements, Sewers, Landscaping, Traffic Study			1989	306,686		25	6,134	6,134	306,686	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	4,620		10			4,620	16
17	Fire Suppression System			1989	1,271		10			1,271	17
18	Generator			1989	14,937		10			14,937	18
19	Intercom System			1989	650		10			650	19
20	Facility Signs			1989	3,234		10			3,234	20
21	Baseboard Heater			1989	672		10			672	21
22	Carpet			1989	7,664		10			7,664	22
23	Cubicle Track			1989	6,294		10			6,294	23
24	Entry Concrete Slab			1990	6,197		25	124	124	5,660	24
25	Roof Valley			1991	4,140		40	52	52	2,372	25
26	Sign			1991	3,733		10			3,733	26
27	Monument Sign			1992	1,737		10			1,737	27
28	Irrigation System			1993	10,125		25	203	203	8,539	28
29	Parking Lot Expansion			1994	3,475		25	70	70	2,757	29
30	Ceramic Sink			1994	2,011		10			2,011	30
31	Parking Lot Expansion			1995	56,648		25	1,133	1,133	42,108	31
32	Irrigation System			1995	2,029		25	41	41	1,508	32
33	Parking Lot			1997	39,664		25	794	794	27,765	33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Rosewood Care Ctr of Peoria # 0049312 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	
37	Building Improvements - Real Estate Entity, continued		$	$		$	$	$	37
38									38
39	Parking Lot Sealing & Striping	2004	21,277		25	426	426	9,007	39
40	Backflow Preventers	2005	6,600		10	330	330	6,160	40
41	Roof	2005	89,412		40	1,118	1,118	19,745	41
42	Door Closers	2005	2,870		10	144	144	2,463	42
43	Console Heat Pumps	2006	6,337		10	317	317	5,281	43
44	Heat Pumps	2007	3,320		10	166	166	3,241	44
45	Cooling Tower	2008	50,686		10	2,535	2,535	30,834	45
46	Cooling Unit for Walk-In Cooler	2008	3,700		10	185	185	2,251	46
47	Seal and Stripe Parking Lot	2008	6,490		25	130	130	1,558	47
48	Cabinet/Countertops	2009	4,347		10	218	218	2,246	48
49	Telephone System	2009	30,716		10	1,536	1,536	15,870	49
50	Generator	2009	4,781		10	239	239	2,351	50
51	Sprinkler Pipe	2010	2,928		10	147	147	1,269	51
52	Asphalt Parking Lot	2010	61,200		25	1,224	1,224	9,588	52
53	Sidewalks	2010	7,200		25	144	144	1,152	53
54	Water Heater	2011	3,016		10	151	151	905	54
55	Doors	2011	19,324		10	966	966	5,475	55
56	Replace Boiler	2012	7,842		10	392	392	1,950	56
57	Sprinkler	2012	3,830		10	192	192	830	57
58	Sidewalks	2012	5,239		25	105	105	367	58
59	Tuckpointing	2012	4,482		40	56	56	205	59
60	Shower Renovation - new flooring, new Az Rock wall system,	2012	45,215		40	565	565	1,978	60
61	new shower heads, handles & drains								61
62	Water Filtration System	2013	3,997		40	50	50	125	62
63	HVAC Unit	2013	5,257		40	66	66	164	63
64	Sprinkler	2012	16,874		40	211	211	813	64
65	New HVAC Unit	2013	3,760		40	43	43	86	65
66	Door	2013	3,300		40	31	31	62	66
67	Grease Trap	2013	6,293		40	46	46	92	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,814,605	$		$ 56,363	$ 56,363	$ 2,389,581	70

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

Facility Name & ID Number Rosewood Care Ctr of Peoria # 0049312 Report Period Beginning: 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		$ 3,814,605	$		$ 56,363	$ 56,363	$ 2,389,581	1
2	Building Improvements - Real Estate Entity, continued								2
3									3
4									4
5									5
6	Boiler Pump	2013	2,700		10	135	135	270	6
7	Cooling Tower	2013	2,639		10	11	11	22	7
8	Fire Alarm Panel	2014	4,995		10	21	21	42	8
9	Sprinkler	2014	4,287		40	9	9	18	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)		$ 3,829,226	$		$ 56,539	$ 56,539	$ 2,389,933	34

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

Facility Name & ID Number Rosewood Care Ctr of Peoria # 0049312 Report Period Beginning: 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 12B, Carried Forward		$ 3,829,226	$		$ 56,539	$ 56,539	$ 2,389,933	1
2	Leasehold Improvements - Operating Entity								2
3									3
4	Firestopping	2013	3,285	657	5	657		712	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,832,511	$ 657		$ 57,196	$ 56,539	$ 2,390,645	34

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

Facility Name & ID Number Rosewood Care Ctr of Peoria # 0049312 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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	$ 55,789	$ 10,993	$ 10,993	$	5	$ 16,542	71
72	Current Year Purchases	5,712	854	854		5	854	72
73	Fully Depreciated Assets							73
74	Allocated from Mgmt Co/Real Estate Entity	920,044		19,737	19,737		848,876	74
75	TOTALS	$ 981,545	$ 11,847	$ 31,584	$ 19,737		$ 866,272	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,688,540	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 12,504	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 88,780	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 76,276	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,256,917	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Rosewood Care Ctr of Peoria # 0049312 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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. [X] 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:	1989	120	12/1/07	$ 620,261	5	Unlimited	3
4	Additions							4
5								5
6								6
7	TOTAL		120		$ 620,261 **			7

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 [X] NO Terms: N/A *

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	$

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

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO
16. Rental Amount for movable equipment: $ 35,544 Description: Medical Equipment $24,256; Offsite Storage $2,095, Home Office Allocation - $9,193
    (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	Patient	2012 Ford E350 Van	$ 678.33	$ 8,140	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 of Peoria # 0049312 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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

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.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Rosewood Care Ctr of Peoria # 0049312 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	10,260	$ 371,720	$	10,260	$ 371,720	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,316	107,054		2,316	107,054	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		10,385	431,332	2,985	10,385	434,317	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				207,611		207,611	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			$	22,961	$ 910,106	$ 210,596	22,961	$ 1,120,702	14

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

Facility Name & ID Number Rosewood Care Ctr of Peoria # 0049312 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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 10,359	$ 50,716	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 264,305)	1,284,733	1,284,733	3
4	Supply Inventory (priced at Cost)	3,710	3,710	4
5	Short-Term Investments			5
6	Prepaid Insurance	21,990	24,386	6
7	Other Prepaid Expenses	3,434	3,434	7
8	Accounts Receivable (owners or related parties)	448,558	448,558	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,772,784	$ 1,815,537	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		2,851,771	14
15	Leasehold Improvements, at Historical Cost		980,740	15
16	Equipment, at Historical Cost	64,786	981,545	16
17	Accumulated Depreciation (book methods)	(18,108)	(3,256,917)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		140,901	21
22	Other Long-Term Assets (spe Loan Fees		242,368	22
23	Other(specify): Deposits	2,000	2,000	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 48,678	$ 2,816,892	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,821,462	$ 4,632,429	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 565,448	$ 594,983	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	184,955	184,955	30
31	Accrued Taxes Payable (excluding real estate taxes)	25,739	25,739	31
32	Accrued Real Estate Taxes(Sch.IX-B)		99,871	32
33	Accrued Interest Payable		54,144	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	10,512	25,922	35
	Other Current Liabilities(specify):			
36	Accrued Expenses	177,218	239,266	36
37	Accrued Rent	559,457		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,523,329	$ 1,224,880	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,284,715	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)**	$	$ 11,284,715	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,523,329	$ 12,509,595	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 298,133	$ (7,877,166)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,821,462	$ 4,632,429	48

***(See instructions.)**

Facility Name & ID Number Rosewood Care Ctr of Peoria # 0049312 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 288,602	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	429	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 289,031	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	9,102	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)**	$ 9,102	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)**	$ 298,133	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Rosewood Care Ctr of Peoria # 0049312 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,933,369	1
2	Discounts and Allowances for all Levels	(2,078,285)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,855,084	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	449,690	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 449,690	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	9,374	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	68,455	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 79,029	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	20,223	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 20,223	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached Schedule	4,601	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,601	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,408,627	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,097,301	31
32	Health Care	3,217,105	32
33	General Administration	1,078,098	33
	B. Capital Expense		
34	Ownership	1,229,638	34
	C. Ancillary Expense		
35	Special Cost Centers	553,104	35
36	Provider Participation Fee	224,279	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,399,525	40
41	**Income before Income Taxes (line 30 minus line 40)****	9,102	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 9,102	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,582,546	44
45	Private Pay - Net Inpatient Revenue	2,376,453	45
46	Medicare - Net Inpatient Revenue	2,404,998	46
47	Other-(specify) Insurance	491,087	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,855,084	49

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

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

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

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

Rosewood Care Ctr of Peoria

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

Schedule 19A

Other Revenue:

Vending Income	**2,430**
Vendor Discount	**1,802**
Miscellaneous	**369**
Total Other Revenue	**4,601**

Facility Name & ID Number Rosewood Care Ctr of Peoria # 0049312 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 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,018	2,109	$ 60,516	$ 28.69	1
2	Assistant Director of Nursing	1,292	1,343	35,682	26.57	2
3	Registered Nurses	14,388	15,173	334,407	22.04	3
4	Licensed Practical Nurses	22,284	23,945	477,041	19.92	4
5	CNAs & Orderlies	77,629	81,802	846,279	10.35	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,836	2,075	21,679	10.45	8
9	Activity Director	2,160	2,392	40,216	16.81	9
10	Activity Assistants	3,686	4,003	34,379	8.59	10
11	Social Service Workers	3,644	3,840	42,241	11.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,784	23,751	236,750	9.97	15
16	Dishwashers					16
17	Maintenance Workers	2,202	2,380	41,269	17.34	17
18	Housekeepers	16,873	17,780	148,010	8.32	18
19	Laundry	4,292	4,573	42,529	9.30	19
20	Administrator	2,049	2,209	72,318	32.74	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,468	8,987	90,687	10.09	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	3,638	3,885	40,370	10.39	31
32	Other Health Care(specify)					32
33	Other(specify) See Sch 20A	9,499	10,157	202,432	19.93	33
34	TOTAL (lines 1 - 33)	197,742	210,404	$ 2,766,805 *	$ 13.15	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 6,410	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	7,782	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	2,600	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)		$ 37,192		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	72	$ 3,025	L10, C3	50
51	Licensed Practical Nurses	576	18,866	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	648	$ 21,891		53

Rosewood Care Ctr of 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
Case Manager		3,275	3,509	77,302	22.03
Ward Clerk		2,314	2,432	51,264	21.08
Marketing		3,910	4,216	73,866	17.52
	TOTAL	9,499	10,157	202,432	

Facility Name & ID Number Rosewood Care Ctr of Peoria # 0049312 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Tim Bledsoe	Administrator	0	$ 29,311
Lorene Foust	Administrator	0	28,756
Randi Lienhart	Administrator	0	14,251
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 72,318

B. Administrative - Other

Description	Amount
Mgmt Fees-Bravo Nursing Home Svc-See Page 6, Elimon P 3, C 7	$ 138,000
Mgmt Fees-Midwest Admin Svc-See Page 6, Elimon P 3, C 7 from 1/1/14-6/30/14 (post-acquisition)	101,101
TOTAL (agree to Schedule V, line 17, col. 3)	$ 239,101
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Hochschild, Bloom & Company	Accountant/Consultant	$ 3,394
Midwest Administrative Services	Administrative/Bookkeeping	122,768
Claims Administration Services, Inc.	Related Party Legal Fees	3,197
Daniel Maher	Legal Fees	6,474
Healthcare Horizons	Healthcare Consultant	1,135
Livingston Barger	Legal Fees	2,245
Peoria County Circuit Court	Court Costs	148
Senior Care Capital	Loan Fees	7,500
US Managed Care Services	Managed Care Network	200
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 147,061

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 72,249
Unemployment Compensation Insurance	70,662
FICA Taxes	209,210
Employee Health Insurance	29,750
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	3,091
Employee Uniforms	763
Employee Physicals	1,942
Employee Drug Tests	320
Tuition Reimbursement	945
TOTAL (agree to Schedule V, line 22, col.8)	$ 388,932

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	10,231
Health Care Worker Background Check	
(Indicate # of checks performed)	2,792
Patient Background Checks	
Misc. Dues/Subscriptions/Fees	419
Rosewood License Fee	1,500
IHCA Dues	4,232
Misc. Licenses & Fees	2,575
Home Office Allocation	1,586
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,315

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Home Office Allocation	5,787
Seminar Expense	275
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,062

**See instructions.

Facility Name & ID Number Rosewood Care Ctr of Peoria # 0049312 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2	N/A												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Rosewood Care Ctr of Peoria # 0049312 Report 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. $ **51,244** 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. $ **224,279**
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. $ **11,804**

(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.