FOR BHF USE

LL1

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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0049338

Facility Name: Rosewood Cr Ctr East Peoria

Address: 900 Centennial Drive (Number) East Peoria (City) 61611 (Zip Code)

County: Tazewell

Telephone Number: (309) 699-5400 **Fax #** (309) 699-1632

HFS ID Number:

Date of Initial License for Current Owners: 12/1/2007

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 07/01/2014 to 06/30/2015 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) Jack McKittrick
(Title) Chief Financial Officer

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Cr Ctr East Peoria # 0049338 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 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	16,078	12,127	8,212	36,417	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,078	12,127	8,212	36,417	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.14%

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 [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 12/01/2007

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/01/2007 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 36 and days of care provided 5,374

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: 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 Cr Ctr East Peoria # 0049338 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 Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	227,730	29,651	8,284	265,665		265,665	4,841	270,506			1
2	Food Purchase		241,758		241,758		241,758	(7,175)	234,583			2
3	Housekeeping	20,217	12,888	151,977	185,082		185,082		185,082			3
4	Laundry	4,530	12,703	101,318	118,551		118,551		118,551			4
5	Heat and Other Utilities			136,959	136,959		136,959	485	137,444			5
6	Maintenance	30,122	8,595	186,073	224,790		224,790	(21,203)	203,587			6
7	Other (specify):* Allocated HO Benefits							5,170	5,170			7
8	**TOTAL General Services**	282,599	305,595	584,611	1,172,805		1,172,805	(17,882)	1,154,923			8
	B. Health Care and Programs											
9	Medical Director			18,813	18,813		18,813		18,813			9
10	Nursing and Medical Records	2,353,304	198,342	9,601	2,561,247		2,561,247	54,426	2,615,673			10
10a	Therapy		2,806	912,896	915,702		915,702		915,702			10a
11	Activities	55,778	3,660	2,400	61,838		61,838		61,838			11
12	Social Services	53,976		2,400	56,376		56,376		56,376			12
13	CNA Training											13
14	Program Transportation			500	500		500		500			14
15	Other (specify):* Allocated HO Benefits							5,774	5,774			15
16	**TOTAL Health Care and Programs**	2,463,058	204,808	946,610	3,614,476		3,614,476	60,200	3,674,676			16
	C. General Administration											
17	Administrative	98,295		378,829	477,124		477,124	(316,084)	161,040			17
18	Directors Fees											18
19	Professional Services			180,788	180,788		180,788	127,117	307,905			19
20	Dues, Fees, Subscriptions & Promotions			16,462	16,462		16,462	5,143	21,605			20
21	Clerical & General Office Expenses	108,337	18,785	156,033	283,155		283,155	190,615	473,770			21
22	Employee Benefits & Payroll Taxes			430,541	430,541		430,541		430,541			22
23	Inservice Training & Education			59	59		59		59			23
24	Travel and Seminar			1,085	1,085		1,085	10,937	12,022			24
25	Other Admin. Staff Transportation			8,965	8,965		8,965	3,526	12,491			25
26	Insurance-Prop.Liab.Malpractice			(35,788)	(35,788)		(35,788)	14,339	(21,449)			26
27	Other (specify):* Allocated HO Benefits							27,855	27,855			27
28	**TOTAL General Administration**	206,632	18,785	1,136,974	1,362,391		1,362,391	63,448	1,425,839			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,952,289	529,188	2,668,195	6,149,672		6,149,672	105,766	6,255,438			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 Cr Ctr East Peoria #0049338 **Report Period Beginning:** 07/01/2014 **Ending:** 06/30/2015

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			11,621	11,621		11,621	146,335	157,956			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,952	13,952		13,952	258,631	272,583			32
33	Real Estate Taxes							73,787	73,787			33
34	Rent-Facility & Grounds			1,007,147	1,007,147		1,007,147	(994,047)	13,100			34
35	Rent-Equipment & Vehicles			32,967	32,967		32,967	(5,837)	27,130			35
36	Other (specify):* Mortgage Ins.							21,183	21,183			36
37	**TOTAL Ownership**			1,065,687	1,065,687		1,065,687	(499,948)	565,739			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		177,068		177,068		177,068		177,068			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			245,469	245,469		245,469		245,469			42
43	Other (specify):* See Att Sch 4A	76,318		21,333	97,651		97,651	(58,903)	38,748			43
44	**TOTAL Special Cost Centers**	76,318	177,068	266,802	520,188		520,188	(58,903)	461,285			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,028,607	706,256	4,000,684	7,735,547		7,735,547	(453,085)	7,282,462			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 Cr Ctr East 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 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/OP Expenses			28,250	28,250		28,250		28,250			
	Radiology Expenses			10,498	10,498		10,498		10,498			
	Non-Allowable Expenses	76,318		(17,415)	58,903		58,903	(58,903)	0			
					0		0		0			
					0		0		0			
	TOTAL Other Special Cost Centers	76,318	0	21,333	97,651	0	97,651	(58,903)	38,748			

Facility Name & ID Number Rosewood Cr Ctr East Peoria # 0049338 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.)

	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	(6,099)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,321)	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	(2,278)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,077)	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				18
19	Entertainment	(84)	43		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(10,092)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	25,237	43		24
25	Fund Raising, Advertising and Promotional	(4,094)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(461)	43		28
29	Other-Attach Schedule See Page 5A	(93,766)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (101,035)		$	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)	(352,050)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (352,050)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (453,085)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Cr Ctr East Peoria

ID# 0049338

Report Period Beginning: 07/01/2014

Ending: 06/30/2015

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate Marketing Salary	$ (76,318)	43	1
2	Eliminate Lobbying & PAC Dues	(2,804)	20	2
3	Miscellaneous Income Offset	248	21	3
4	Resident Reimbursements	5,138	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	(4,670)	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
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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**	(93,766)		49

Facility Name & ID Number Rosewood Cr Ctr East Peoria # 0049338 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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	1	Dietary	$	Bravo Nursing Home Services, Inc.	0.00%	$ 870	$ 870	1
2	V	6	Maintenance		Bravo Nursing Home Services, Inc.	0.00%	31	31	2
3	V	7	Mgmt. Allocation of Benefits		Bravo Nursing Home Services, Inc.	0.00%	92	92	3
4	V	10	Nursing & Medical Records		Bravo Nursing Home Services, Inc.	0.00%	43,520	43,520	4
5	V	15	Mgmt. Allocation of Benefits		Bravo Nursing Home Services, Inc.	0.00%	4,623	4,623	5
6	V	17	Administrative	138,000	Bravo Nursing Home Services, Inc.	0.00%	15,816	(122,184)	6
7	V	19	Professional Services		Bravo Nursing Home Services, Inc.	0.00%	122	122	7
8	V	20	Dues, Fees, Subs & Promotions		Bravo Nursing Home Services, Inc.	0.00%	61	61	8
9	V	21	Clerical and General Office		Bravo Nursing Home Services, Inc.	0.00%	52,583	52,583	9
10	V	24	Travel and Seminar		Bravo Nursing Home Services, Inc.	0.00%	2,357	2,357	10
11	V	25	Other Admin. Staff Transport.		Bravo Nursing Home Services, Inc.	0.00%	2,082	2,082	11
12	V	26	Insurance-Prop./Liab./Malprac.		Bravo Nursing Home Services, Inc.	0.00%	228	228	12
13	V	27	Mgmt. Allocation of Benefits		Bravo Nursing Home Services, Inc.	0.00%	7,126	7,126	13
14	Total			$ 138,000			$ 129,511	$ * (8,489)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Cr Ctr East Peoria # 0049338 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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%	$ 3,971	$ 3,971	15
16	V	2	Food		Midwest Administrative Services, Inc.	0.00%	1	1	16
17	V	5	Utilities		Midwest Administrative Services, Inc.	0.00%	157	157	17
18	V	6	Maintenance		Midwest Administrative Services, Inc.	0.00%	1,204	1,204	18
19	V	7	Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	419	419	19
20	V	10	Nursing and Medical Records		Midwest Administrative Services, Inc.	0.00%	10,906	10,906	20
21	V	15	Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	1,151	1,151	21
22	V	17	Administrative	240,829	Midwest Administrative Services, Inc.	0.00%	46,929	(193,900)	22
23	V	19	Professional Services		Midwest Administrative Services, Inc.	0.00%	8,349	8,349	23
24	V	20	Dues, Fees, Subs & Promotions		Midwest Administrative Services, Inc.	0.00%	7,816	7,816	24
25	V	21	Clerical and General Office	61,107	Midwest Administrative Services, Inc.	0.00%	172,935	111,828	25
26	V	24	Travel and Seminar		Midwest Administrative Services, Inc.	0.00%	3,652	3,652	26
27	V	25	Other Admin. Staff Transport.		Midwest Administrative Services, Inc.	0.00%	2,079	2,079	27
28	V	26	Insurance-Prop./Liab./Malprac.		Midwest Administrative Services, Inc.	0.00%	4,203	4,203	28
29	V	27	Mgmt. Allocation of Benefits		Midwest Administrative Services, Inc.	0.00%	18,818	18,818	29
30	V	30	Depreciation		Midwest Administrative Services, Inc.	0.00%	17,635	17,635	30
31	V	32	Interest		Midwest Administrative Services, Inc.	0.00%	14,057	14,057	31
32	V	34	Rent-Facility and Grounds		Midwest Administrative Services, Inc.	0.00%	13,100	13,100	32
33	V	35	Rent-Equipment & Vehicles		Midwest Administrative Services, Inc.	0.00%	2,323	2,323	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 301,936			$ 329,705	$ * 27,769	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Cr Ctr East Peoria # 0049338 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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	$ 62,002	Claims Administration Services, LLC	0.00%	$ 308	$ (61,694)	15
16	V	21	Clerical and General Office		Claims Administration Services, LLC	0.00%	17,786	17,786	16
17	V	24	Travel and Seminar		Claims Administration Services, LLC	0.00%	1,025	1,025	17
18	V	25	Other Admin. Staff Transport.		Claims Administration Services, LLC	0.00%	537	537	18
19	V	26	Insurance-Prop./Liab./Malprac.		Claims Administration Services, LLC	0.00%	228	228	19
20	V	27	Mgmt. Allocation of Benefits		Claims Administration Services, LLC	0.00%	1,911	1,911	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			$ 62,002			$ 21,795	$ * (40,207)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Cr Ctr East Peoria # 0049338 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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%	$ 328	$ 328	15
16	V	6	Maintenance	61,274	Senior Living Services, Inc.	0.00%	38,836	(22,438)	16
17	V	7	Mgmt. Allocation of Benefits		Senior Living Services, Inc.	0.00%	4,659	4,659	17
18	V	19	Professional Services		Senior Living Services, Inc.	0.00%	10	10	18
19	V	21	Clerical and General Office		Senior Living Services, Inc.	0.00%	802	802	19
20	V	24	Travel and Seminar		Senior Living Services, Inc.	0.00%	3,594	3,594	20
21	V	25	Other Admin. Staff Transport.		Senior Living Services, Inc.	0.00%	3,181	3,181	21
22	V	26	Insurance-Prop./Liab./Malprac.		Senior Living Services, Inc.	0.00%	938	938	22
23	V	30	Depreciation		Senior Living Services, Inc.	0.00%	1,291	1,291	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			$ 61,274			$ 53,639	$ * (7,635)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Cr Ctr East Peoria # 0049338 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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%	$ 184,332	$ 184,332	15
16	V	20	Fees & Subscriptions		Bravo Holding Company	0.00%	70	70	16
17	V	21	Clerical and General Office		Bravo Holding Company	0.00%	942	942	17
18	V	24	Travel and Seminar		Bravo Holding Company	0.00%	309	309	18
19	V	25	Other Admin. Staff Transport.		Bravo Holding Company	0.00%	317	317	19
20	V	26	Insurance-Prop./Liab./Malprac.		Bravo Holding Company	0.00%	753	753	20
21	V	32	Interest		Bravo Holding Company	0.00%	19,816	19,816	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			$			$ 206,539	$ * 206,539	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Cr Ctr East Peoria # 0049338 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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	17	Administrative	$	East Peoria Real Estate, Inc.	0.00%	$ 7,200	$ 7,200	15
16	V	19	Professional Services		East Peoria Real Estate, Inc.	0.00%	6,090	6,090	16
17	V	21	Clerical and General Office		East Peoria Real Estate, Inc.	0.00%	6,426	6,426	17
18	V	26	Insurance-Prop./Liab./Malprac.		East Peoria Real Estate, Inc.	0.00%	7,989	7,989	18
19	V	30	Depreciation		East Peoria Real Estate, Inc.	0.00%	127,409	127,409	19
20	V	32	Interest	31	East Peoria Real Estate, Inc.	0.00%	227,067	227,036	20
21	V	33	Real Estate Taxes		East Peoria Real Estate, Inc.	0.00%	73,787	73,787	21
22	V	34	Rent-Facility and Grounds	1,007,147	East Peoria Real Estate, Inc.	0.00%		(1,007,147)	22
23	V	36	Mortgage Insurance		East Peoria Real Estate, Inc.	0.00%	21,183	21,183	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			$ 1,007,178			$ 477,151	$ * (530,027)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Cr Ctr East Peoria # 0049338 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

VII. RELATED PARTIES

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Cr Ctr East Peoria # 0049338 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	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	Mark Yampol	CEO	Administrative	0.00	56,267	4.97	9.94	Salary	4,723	L17, C7	1
2	Mark Yampol	CEO	Administrative	0.00	1,383,847	See Above	See Above	Consulting	116,153	L19, C7	2
3	Hillel Yampol	Owner	Administrative	0.00	44,410	4.97	9.94	Salary	3,728	L17, C7	3
4	Christene Rene Yampol	Owner	Administrative	0.00	66,434	4.97	9.94	Salary	5,576	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	$ 130,180		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 Cr Ctr East Peoria # 0049338 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 [X] NO [ ]

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

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

	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	470,290	14	11,239	11,239	36,417	$ 870	1
2	6	Maintenance	WeightedCensus	470,290	14	397		36,417	31	2
3	7	Mgmt. Allocation of Benefits	WeightedCensus	470,290	14	1,193		36,417	92	3
4	10	Nursing & Medical Records	WeightedCensus	470,290	14	562,016	562,016	36,417	43,520	4
5	15	Mgmt. Allocation of Benefits	WeightedCensus	470,290	14	59,699		36,417	4,623	5
6	17	Administrative	WeightedCensus	470,290	14	204,253	204,253	36,417	15,816	6
7	19	Professional Services	WeightedCensus	470,290	14	1,579		36,417	122	7
8	20	Dues, Fees, Subs & Promotions	WeightedCensus	470,290	14	786		36,417	61	8
9	21	Clerical and General Office	WeightedCensus	470,290	14	679,056	662,076	36,417	52,583	9
10	24	Travel and Seminar	WeightedCensus	470,290	14	30,438		36,417	2,357	10
11	25	Other Admin. Staff Transport.	WeightedCensus	470,290	14	26,889		36,417	2,082	11
12	26	Insurance-Prop./Liab./Malprac.	WeightedCensus	470,290	14	2,943		36,417	228	12
13	27	Mgmt. Allocation of Benefits	WeightedCensus	470,290	14	92,023		36,417	7,126	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		$ 129,511	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Cr Ctr East Peoria # 0049338 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 [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	470,290	14	51,283	51,283	36,417	$ 3,971	1
2	2	Food	WeightedCensus	470,290	14	13		36,417	1	2
3	5	Utilities	WeightedCensus	470,290	14	2,032		36,417	157	3
4	6	Maintenance	WeightedCensus	470,290	14	15,554		36,417	1,204	4
5	7	Mgmt. Allocation of Benefits	WeightedCensus	470,290	14	5,409		36,417	419	5
6	10	Nursing and Medical Records	WeightedCensus	470,290	14	140,839	140,839	36,417	10,906	6
7	15	Mgmt. Allocation of Benefits	WeightedCensus	470,290	14	14,860		36,417	1,151	7
8	17	Administrative	WeightedCensus	470,290	14	606,045	606,045	36,417	46,929	8
9	19	Professional Services	WeightedCensus	470,290	14	107,816		36,417	8,349	9
10	20	Dues, Fees, Subs & Promotions	WeightedCensus	470,290	14	100,942		36,417	7,816	10
11	21	Clerical and General Office	WeightedCensus	470,290	14	2,233,257	1,697,067	36,417	172,935	11
12	24	Travel and Seminar	WeightedCensus	470,290	14	47,164		36,417	3,652	12
13	25	Other Admin. Staff Transport.	WeightedCensus	470,290	14	26,845		36,417	2,079	13
14	26	Insurance-Prop./Liab./Malprac.	WeightedCensus	470,290	14	54,274		36,417	4,203	14
15	27	Mgmt. Allocation of Benefits	WeightedCensus	470,290	14	243,011		36,417	18,818	15
16	30	Depreciation	WeightedCensus	470,290	14	227,745		36,417	17,635	16
17	32	Interest	WeightedCensus	470,290	14	181,530		36,417	14,057	17
18	34	Rent-Facility and Grounds	WeightedCensus	470,290	14	169,173		36,417	13,100	18
19	35	Rent-Equipment & Vehicles	WeightedCensus	470,290	14	30,003		36,417	2,323	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,257,795	$ 2,495,234		$ 329,705	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Cr Ctr East Peoria # 0049338 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 [X] NO [ ]

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

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

	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	470,290	14	3,980		36,417	$ 308	1
2	21	Clerical and General Office	WeightedCensus	470,290	14	229,689	226,926	36,417	17,786	2
3	24	Travel and Seminar	WeightedCensus	470,290	14	13,239		36,417	1,025	3
4	25	Other Admin. Staff Transport.	WeightedCensus	470,290	14	6,938		36,417	537	4
5	26	Insurance-Prop./Liab./Malprac.	WeightedCensus	470,290	14	2,943		36,417	228	5
6	27	Mgmt. Allocation of Benefits	WeightedCensus	470,290	14	24,684		36,417	1,911	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		$ 21,795	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Cr Ctr East Peoria # 0049338 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 [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	470,290	14	4,237		36,417	$ 328	1
2	6	Maintenance	WeightedCensus/Direct Exp	470,290	14	513,005	471,253	36,417	38,836	2
3	7	Mgmt. Allocation of Benefits	WeightedCensus	470,290	14	60,169		36,417	4,659	3
4	19	Professional Services	WeightedCensus	470,290	14	123		36,417	10	4
5	21	Clerical and General Office	WeightedCensus	470,290	14	10,353		36,417	802	5
6	24	Travel and Seminar	WeightedCensus	470,290	14	46,417		36,417	3,594	6
7	25	Other Admin. Staff Transport.	WeightedCensus	470,290	14	41,082		36,417	3,181	7
8	26	Insurance-Prop./Liab./Malprac.	WeightedCensus	470,290	14	12,112		36,417	938	8
9	30	Depreciation	WeightedCensus	470,290	14	16,668		36,417	1,291	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		$ 53,639	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Cr Ctr East Peoria # 0049338 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 [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	470,290	14	2,380,463		36,417	$ 184,332	1
2	20	Fees & Subscriptions	WeightedCensus	470,290	14	901		36,417	70	2
3	21	Clerical and General Office	WeightedCensus	470,290	14	12,160		36,417	942	3
4	24	Travel and Seminar	WeightedCensus	470,290	14	3,989		36,417	309	4
5	25	Other Admin. Staff Transport.	WeightedCensus	470,290	14	4,094		36,417	317	5
6	26	Insurance-Prop./Liab./Malprac.	WeightedCensus	470,290	14	9,723		36,417	753	6
7	32	Interest	WeightedCensus	470,290	14	255,901		36,417	19,816	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	$		$ 206,539	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Cr Ctr East Peoria # 0049338 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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	$70,396.80	10/1/03	$ 10,665,100	$ 8,974,060	11/1/38	0.0496	$ 223,970	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	74,129	6
7	Bravo Holding Co.)											7
8												8
9	TOTAL Facility Related				$70,396.80		$ 10,665,100	$ 8,974,060			$ 298,099	9
	B. Non-Facility Related*											
10							Less: Interest Income Offset				(62,486)	10
11							Amortization Expense				3,097	11
12							Allocated from Mgmt Co's				33,873	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (25,516)	14
15	TOTALS (line 9+line14)						$ 10,665,100	$ 8,974,060			$ 272,583	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 21,183 **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.)**

Facility Name & ID Number Rosewood Cr Ctr East Peoria # 0049338 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 73,787	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	**See Below**	$ 72,091	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,696)	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 75,483	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.		$ 73,787	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:				
		2010	66,234	8
Taxes Paid-2013	36,170	2011	65,673	9
Taxes Paid-2014	35,921	2012	71,875	10
Total Taxes Paid	72,091	2013	72,340	11
		2014	71,843	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rosewood Cr Ctr East Peoria COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0049338

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	01-01-24-100-024	900 Centennial Drive	$ 71,842.58	$ 71,842.58
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 71,842.58	$ 71,842.58

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 Cr Ctr East Peoria # 0049338 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,125 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [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	301,000	1988	$ 64,385	1
2					2
3	TOTALS	301,000		$ 64,385	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Cr Ctr East Peoria # 0049338 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 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	$ 2,961,197	$	40	$ 74,030	$ 74,030	$ 1,943,286	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements - Real Estate Entity										9
10											10
11	Improvements-Original Construction			1989	209,624		25			209,624	11
12	Generator			1989	14,937		10			14,937	12
13	Signs			1989	3,157		10			3,157	13
14	Walk-in Cooler			1989	5,770		10			5,770	14
15	Sinks			1989	3,744		10			3,744	15
16	Exhaust Hood			1989	4,621		10			4,621	16
17	Fire System			1989	1,271		10			1,271	17
18	Carpeting			1989	10,368		10			10,368	18
19	Cubicle Track			1989	6,294		10			6,294	19
20	Fence			1990	2,377		25	95	95	2,353	20
21	Concrete Work			1991	5,190		25	208	208	4,983	21
22	Door Installation			1991	2,750		10			2,750	22
23	Painting			1992	7,694						23
24	Sprinkler Addition			1992	786		10			786	24
25	Irrigation System			1993	10,175		25	407	407	8,988	25
26	Ceramic Sink			1994	2,011		10			2,011	26
27	Parking Lot Extension			2003	37,488		25	1,500	1,500	17,495	27
28	Shingle Roof Replacement			2004	97,105		40				28
29	Door Closures			2005	2,870		10	287	287	2,750	29
30	Patient Room Sinks			2006	12,035		10	1,204	1,204	11,187	30
31	Heat Pumps			2006	28,515		10	2,852	2,852	26,378	31
32	2 Copper Exchange Boilers			2006	4,400		10	440	440	3,813	32
33	Seal & Stripe Parking Lot			2006	3,275		25	131	131	1,157	33
34	Cooling Towers			2007	47,061		10	4,706	4,706	38,433	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Cr Ctr East Peoria # 0049338 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 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	Generator Replacement/Upgrade	2008	11,915		10	1,192	1,192	8,690	39
40	Water Piping	2008	3,583		10	358	358	2,836	40
41	Heat Pumps	2008	2,885		10	289	289	2,140	41
42	Parking Lot Light Fixtures	2008	3,125		10	313	313	2,292	42
43	Water Softener	2008	7,643		10	764	764	5,286	43
44	Condensor HVAC	2008	4,800		10	480	480	3,200	44
45	Seal & Stripe Parking Lot	2008	3,895		25	156	156	1,091	45
46	Telephone System	2008	16,974		10	1,697	1,697	12,023	46
47	Emergency Power System Generator	2009	29,688		10	2,969	2,969	18,803	47
48	New Counter Tops	2009	4,347		10	435	435	2,681	48
49	Mcquay Heat Pumps	2009	37,963		10	3,796	3,796	21,512	49
50	Boiler	2009	3,250		10	325	325	1,842	50
51	Carpet	2010	10,123		10	1,012	1,012	5,439	51
52	Water Heater	2010	3,990		10	399	399	2,161	52
53	Doors	2010	1,275		10	128	128	659	53
54	Sealcoat Parking Lot	2010	4,255		25	170	170	851	54
55	Sprinkler	2012	20,131		40	503	503	1,300	55
56	Curb Sidewalk Concrete	2012	13,086		25	523	523	1,483	56
57	Water Filtration System	2013	4,147		40	104	104	234	57
58	Replace Sidewalk and Repair Dumpster	2013	2,640		40	66	66	138	58
59	Windows and Screens	2013	2,755		40	69	69	144	59
60	Sprinkler	2013	17,352		40	434	434	795	60
61	Door Replacement	2013	21,726		40	543	543	950	61
62	Grease Trap	2013	7,080		40	177	177	295	62
63	Parking Lot Expansion	2013	4,550		25	182	182	329	63
64	HVAC Improvements	2014	51,737		10	5,174	5,174	7,621	64
65	Water Softener	2014	5,033		10	503	503	587	65
66	Cooling Tower	2014	3,136		10	314	314	340	66
67	Seal Coating	2014	5,950		25	178	178	178	67
68	Replaced Hot Water Heater	2015	2,716		10	113	113	113	68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,796,465	$		$ 109,226	$ 109,226	$ 2,432,169	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rosewood Cr Ctr East Peoria # 0049338 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 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		$ 3,796,465	$		$ 109,226	$ 109,226	$ 2,432,169	1
2	Leasehold Improvements - Operating Entity								2
3									3
4	Boiler Expansion Tank & Pressure Gauge	2008	3,450	493	7	493		3,286	4
5	Carpet For Lounge & Dining Room	2009	3,691	527	7	527		3,163	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)		$ 3,803,606	$ 1,020		$ 110,246	$ 109,226	$ 2,438,618	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rosewood Cr Ctr East Peoria # 0049338 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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	$ 53,003	$ 10,601	$ 10,601	$	5-10	$ 25,908	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Allocated from Mgmt Co/Real Estate Entity	872,864		37,109	37,109	10	815,233	74
75	TOTALS	$ 925,867	$ 10,601	$ 47,710	$ 37,109		$ 841,141	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,793,858	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 11,621	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 157,956	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 146,335	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,279,759	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	Renovation Project	$ 50,000	92
93			93
94			94
95		$ 50,000	95

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rosewood Cr Ctr East Peoria # 0049338 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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				13,100			6
7	TOTAL				$ 13,100 **			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 ☐ NO Terms: _____ *

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	$

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: $ 27,130 Description: Offsite Storage - $1,966, Medical Equipment - $22,841, Home Office Allocation - $2,323
    (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	N/A		$	$	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 Cr Ctr East Peoria # 0049338 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.)

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Cr Ctr East Peoria # 0049338 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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	$	10,649	$ 404,663	$	10,649	$ 404,663	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,654	76,096		1,654	76,096	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		11,372	432,137	2,806	11,372	434,943	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				177,068		177,068	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			$	23,675	$ 912,896	$ 179,874	23,675	$ 1,092,770	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

STATE OF ILLINOIS

Facility Name & ID Number Rosewood Cr Ctr East Peoria # 0049338 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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (23,070)	$ (4,756)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 253,000)	1,547,706	1,547,706	3
4	Supply Inventory (priced at Cost)	4,330	4,330	4
5	Short-Term Investments			5
6	Prepaid Insurance	25,858	29,218	6
7	Other Prepaid Expenses	4,215	4,215	7
8	Accounts Receivable (owners or related parties)	1,784,095	1,784,095	8
9	Other(specify): Insurance Deductible AR	24,958	24,958	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,368,092	$ 3,389,766	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		64,385	13
14	Buildings, at Historical Cost		2,961,197	14
15	Leasehold Improvements, at Historical Cost	7,141	842,409	15
16	Equipment, at Historical Cost	53,003	925,867	16
17	Accumulated Depreciation (book methods)	(32,357)	(3,279,759)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		90,833	21
22	Other Long-Term Assets (spe Loan Fees		163,160	22
23	Other(specify): Deposits	2,000	52,000	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 29,787	$ 1,820,092	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,397,879	$ 5,209,858	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 727,556	$ 747,262	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	152,998	152,998	30
31	Accrued Taxes Payable (excluding real estate taxes)	50,101	50,101	31
32	Accrued Real Estate Taxes(Sch.IX-B)		75,483	32
33	Accrued Interest Payable		6,426	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	8,885	30,855	35
	Other Current Liabilities(specify):			
36	Accrued Expenses	543,240	554,440	36
37	Accrued Rent	935,041	(2,416)	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,417,821	$ 1,615,149	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,974,060	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)**	$	$ 8,974,060	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,417,821	$ 10,589,209	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 980,058	$ (5,379,351)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,397,879	$ 5,209,858	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Rosewood Cr Ctr East Peoria # 0049338 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 338,809	1	
2	Restatements (describe):		2	
3	**Prior year post closing adjustments**	84,940	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 423,749	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	556,309	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)**	$ 556,309	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)**	$ 980,058	24	*

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Cr Ctr East Peoria # 0049338 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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	$ 10,200,338	1
2	Discounts and Allowances for all Levels	(2,313,510)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,886,828	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	333,941	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 333,941	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	1,750	13
14	Non-Patient Meals	3,877	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	60,131	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 65,758	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,278	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,278	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached Schedule 19A	3,051	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,051	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,291,856	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,172,805	31
32	Health Care	3,614,476	32
33	General Administration	1,362,391	33
	B. Capital Expense		
34	Ownership	1,065,687	34
	C. Ancillary Expense		
35	Special Cost Centers	274,719	35
36	Provider Participation Fee	245,469	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,735,547	40
41	**Income before Income Taxes (line 30 minus line 40)****	556,309	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 556,309	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,202,319	44
45	Private Pay - Net Inpatient Revenue	2,254,302	45
46	Medicare - Net Inpatient Revenue	2,556,887	46
47	Other-(specify) Insurance/Managed Care	873,320	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,886,828	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 Cr Ctr East Peoria

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

Schedule 19A

Other Revenue:

Vending Income	**2,222**
Vendor Discount	**1,077**
Miscellaneous	**(248)**
Total Other Revenue	**3,051**

Facility Name & ID Number Rosewood Cr Ctr East Peoria # 0049338 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 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,172	2,320	$ 66,547	$ 28.68	1
2	Assistant Director of Nursing	2,378	2,466	57,735	23.41	2
3	Registered Nurses	17,001	17,895	440,456	24.61	3
4	Licensed Practical Nurses	24,046	25,775	499,750	19.39	4
5	CNAs & Orderlies	91,227	96,701	1,006,570	10.41	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,014	2,182	23,060	10.57	8
9	Activity Director	2,208	2,371	23,434	9.88	9
10	Activity Assistants	3,516	3,796	32,344	8.52	10
11	Social Service Workers	4,294	4,593	53,976	11.75	11
12	Dietician					12
13	Food Service Supervisor	2,076	2,310	28,321	12.26	13
14	Head Cook	8,082	8,461	78,172	9.24	14
15	Cook Helpers/Assistants	11,876	12,898	121,237	9.40	15
16	Dishwashers					16
17	Maintenance Workers	2,315	2,517	30,122	11.97	17
18	Housekeepers	1,383	2,078	20,217	9.73	18
19	Laundry	386	527	4,530	8.60	19
20	Administrator	2,184	2,364	98,295	41.58	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,022	9,661	108,337	11.21	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	3,076	3,265	28,332	8.68	31
32	Other Health Care(specify)					32
33	Other(specify) See Sch 20A	14,731	15,992	307,172	19.21	33
34	TOTAL (lines 1 - 33)	203,987	218,172	$ 3,028,607 *	$ 13.88	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	$ 8,284	L1, C3	35
36	Medical Director	Monthly	18,813	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,696	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)		$ 39,593		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Cr Ctr East 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		**2,200**	**2,445**	**51,636**	21.12
Case Manager		**3,712**	**4,163**	**84,740**	20.36
Rehabilitation Nurse		**2,199**	**2,343**	**45,841**	19.57
Ward Clerk		**2,335**	**2,448**	**48,637**	19.87
Marketing		**4,285**	**4,593**	**76,318**	16.62
	TOTAL	**14,731**	**15,992**	**307,172**	

Facility Name & ID Number Rosewood Cr Ctr East Peoria # 0049338 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Becky Woiwode	Administrator	0	$ 98,295
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 98,295

B. Administrative - Other

Description	Amount
Mgmt Fees-Bravo Nursing Home Svc-See Pg 6, Elim on P 3, C 7	$ 138,000
Mgmt Fees-Midwest Admin Svc-See Pg 6, Elim on P 3, C 7	240,829
TOTAL (agree to Schedule V, line 17, col. 3)	$ 378,829
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Hochschild, Bloom & Company	Accountant/Consultant	$ 3,120
WestLaw	Computer Consulting	1,533
Odessa Healthcare	Consultant	75,303
Claims Administration Services, Inc.	Related Party Legal Fees	62,002
NMS Labs	Forensic Testing	1,007
Livingston Barger	Legal Fees	1,887
Daniel Maher	Legal Fees	12,124
Myers Carden & Sax	Legal Fees	3,222
Hamlin & Burton Liability Manager	Insurance Consultant	(500)
Various	Various below $200	410
Various	Deposition/Witness/Court Costs	20,680
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 180,788

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 84,681
Unemployment Compensation Insurance	71,394
FICA Taxes	227,007
Employee Health Insurance	37,217
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	2,699
Employee Uniforms	1,045
Employee Physicals	1,970
Employee Drug Tests	40
Tuition Reimbursement	2,270
401K Expense	2,218
TOTAL (agree to Schedule V, line 22, col.8)	$ 430,541

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	2,133
Health Care Worker Background Check	
(Indicate # of checks performed 177)	3,372
Patient Background Checks	
Misc. Dues/Subscriptions/Fees	704
IHCA Dues	4,501
Misc. Licenses	958
Home Office Allocation	7,947
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,605

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	250
Home Office Allocation	10,937
Seminar Expense	835
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,022

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Cr Ctr East Peoria # 0049338 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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													
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 Cr Ctr East Peoria **#** 0049338 **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. **4,501 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. $ **53,781** 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. $ **245,469**
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. $ **6,009**

(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.