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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0049312

Facility Name: Rosewood Care Center Of Peoria

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

County: Peoria

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

HFS ID Number: [redacted]

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: Steven N. Lavenda **Telephone Number:** ([redacted]
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 07/01/15 to 06/30/16 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) _____

(Firm Name & Address) Marcum, LLP
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 282-6300 Fax # (847) 282-6301

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 Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	43,920	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	43,920	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	13,237	6,251	6,686	26,174	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,237	6,251	6,686	26,174	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.59%

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]

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 4,439

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: 6/30/16 Fiscal Year: 6/30/16

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

Facility Name & ID Number Rosewood Care Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	37,353	5,053	352,780	395,186		395,186	367	395,553			1
2	Food Purchase		236,037		236,037		236,037	(12,016)	224,021			2
3	Housekeeping		13,105	179,033	192,138		192,138		192,138			3
4	Laundry			119,355	119,355		119,355		119,355			4
5	Heat and Other Utilities			131,390	131,390		131,390	(4,559)	126,831			5
6	Maintenance	43,689	6,007	245,701	295,397		295,397	(65,820)	229,577			6
7	Other (specify):*							4,758	4,758			7
8	**TOTAL General Services**	81,042	260,202	1,028,259	1,369,503		1,369,503	(77,270)	1,292,233			8
	B. Health Care and Programs											
9	Medical Director			18,100	18,100		18,100		18,100			9
10	Nursing and Medical Records	1,506,041	203,660	312,231	2,021,932		2,021,932	23,355	2,045,287			10
10a	Therapy	65,672	2,337		68,009		68,009		68,009			10a
11	Activities	79,227	3,999	2,000	85,226		85,226		85,226			11
12	Social Services	41,115	112	2,200	43,427		43,427		43,427			12
13	CNA Training											13
14	Program Transportation			5,830	5,830		5,830		5,830			14
15	Other (specify):*							2,284	2,284			15
16	**TOTAL Health Care and Programs**	1,692,055	210,108	340,361	2,242,524		2,242,524	25,639	2,268,163			16
	C. General Administration											
17	Administrative	71,684		329,434	401,118		401,118	(287,710)	113,408			17
18	Directors Fees											18
19	Professional Services			86,601	86,601		86,601	30,663	117,264			19
20	Dues, Fees, Subscriptions & Promotions			14,655	14,655		14,655	(759)	13,896			20
21	Clerical & General Office Expenses	91,421	23,292	442,402	557,115		557,115	(241,502)	315,613			21
22	Employee Benefits & Payroll Taxes			279,647	279,647		279,647		279,647			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,749	1,749		1,749	994	2,743			24
25	Other Admin. Staff Transportation			7,582	7,582		7,582	6,843	14,425			25
26	Insurance-Prop.Liab.Malpractice			62,859	62,859		62,859	13,226	76,085			26
27	Other (specify):*							20,755	20,755			27
28	**TOTAL General Administration**	163,105	23,292	1,224,929	1,411,326		1,411,326	(457,490)	953,836			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,936,202	493,602	2,593,549	5,023,353		5,023,353	(509,120)	4,514,233			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 Center Of Peoria #0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

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			17,226	17,226		17,226	138,850	156,076			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			101,535	101,535		101,535	556,489	658,024			32
33	Real Estate Taxes							101,067	101,067			33
34	Rent-Facility & Grounds			1,061,147	1,061,147		1,061,147	(1,047,442)	13,705			34
35	Rent-Equipment & Vehicles			9,920	9,920		9,920	(9,897)	23			35
36	Other (specify):*			20,862	20,862		20,862	34,892	55,754			36
37	TOTAL Ownership			1,210,690	1,210,690		1,210,690	(226,041)	984,649			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		224,974	862,005	1,086,979		1,086,979		1,086,979			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			195,827	195,827		195,827		195,827			42
43	Other (specify):*	88,141		3,250	91,391		91,391	(91,391)	(0)			43
44	TOTAL Special Cost Centers	88,141	224,974	1,061,082	1,374,197		1,374,197	(91,391)	1,282,806			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,024,343	718,576	4,865,321	7,608,240		7,608,240	(826,553)	6,781,687			45

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

Facility Name & ID Number Rosewood Care Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	(4,496)	02		4
5	Telephone, TV & Radio in Resident Rooms	(4,915)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2,049	30		9
10	Interest and Other Investment Income	(38,945)	32		10
11	Discounts, Allowances, Rebates & Refunds	(6,125)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(564)	02		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	(120)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(375,880)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(511)	20		28
29	Other-Attach Schedule	(214,974)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (644,481)		$	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)	(182,071)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (182,071)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (826,552)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Rosewood Care Center Of Peoria

ID# 0049312

Report Period Beginning: 07/01/15

Ending: 06/30/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non Allowable Travel	$ (4,097)	25	1
2	Marketing Expenses	(3,250)	43	2
3	Bank Charges	(3,243)	21	3
4	Vending Income	(831)	02	4
5	Midcap Line of Credit Fees	(20,862)	36	5
6	Marketing Salary	(88,141)	43	6
7	Transitions Hospice AR Reserve	(17,054)	21	7
8	Vendor Late Charges	(11,458)	21	8
9	Bldg Co - Audit Fees	(4,100)	19	9
10	Bldg Co - Prof Fees	(883)	19	10
11	Bldg Co - Bank Charges	(15,525)	21	11
12	Bldg Co - Amortization	(6,075)	36	12
13	Miscellaneous Income	(511)	21	13
14	PAC Dues	(2,588)	20	14
15	Capitalized R&M	(31,472)	06	15
16	Non Allowable Legal	(4,885)	19	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**	(214,974)		49

STATE OF ILLINOIS **Page 5B**

Rosewood Care Center Of Peoria

ID# **0049312**

Report Period Beginning: **07/01/15**

Ending: **06/30/16**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Center Of Peoria **#** 0049312 **Report Period Beginning:** 07/01/15 **Ending:** 06/30/16

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary				367								367	1
2	Food Purchase	(12,016)											(12,016)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(4,915)		125				231					(4,559)	5
6	Maintenance	(31,472)		76				(34,424)					(65,820)	6
7	Other (specify):*				39			4,719					4,758	7
8	**TOTAL General Services**	(48,403)		201	406			(29,474)					(77,270)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				23,355								23,355	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				2,284								2,284	15
16	**TOTAL Health Care and Programs**				25,639								25,639	16
	C. General Administration													
17	Administrative			(191,434)	(101,918)	5,642							(287,710)	17
18	Directors Fees													18
19	Professional Services	(9,868)	4,983	91	66	15,016	20,262	112					30,663	19
20	Fees, Subscriptions & Promotions	(3,099)		1,844	2	192	195	107					(759)	20
21	Clerical & General Office Expenses	(423,791)	22,725	115,076	368	260	43,455	406					(241,502)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			378	134	232	250						994	24
25	Other Admin. Staff Transportation	(4,097)		1,915	2,421	1,173	2,672	2,759					6,843	25
26	Insurance-Prop.Liab.Malpractice		8,980	3,319				927					13,226	26
27	Other (specify):*			15,293	2,903		2,558						20,755	27
28	**TOTAL General Administration**	(440,855)	36,688	(53,517)	(96,025)	22,515	69,392	4,312					(457,490)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(489,257)	36,688	(53,316)	(69,980)	22,515	69,392	(25,163)					(509,120)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Center Of Peoria **#** 0049312 **Report Period Beginning:** 07/01/15 **Ending:** 06/30/16

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	2,049	123,239	12,528				1,034					138,850	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(38,945)	582,085	14,336		(987)							556,489	32
33	Real Estate Taxes		101,067										101,067	33
34	Rent-Facility & Grounds		(1,059,092)	11,650									(1,047,442)	34
35	Rent-Equipment & Vehicles			(9,920)	7	5		10					(9,897)	35
36	Other (specify):*	(26,937)	61,829										34,892	36
37	**TOTAL Ownership**	(63,833)	(190,872)	28,594	7	(982)		1,044					(226,041)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(91,391)											(91,391)	43
44	**TOTAL Special Cost Centers**	(91,391)											(91,391)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(644,481)	(154,184)	(24,722)	(69,973)	21,533	69,392	(24,118)					(826,553)	45

Facility Name & ID Number Rosewood Care Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

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
See Pg. 6-Supplemental		See Pg. 6-Supplemental		See Pg. 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	34	Rental Income	$ 1,059,092	Peoria Real Estate	100.00%	$	$ (1,059,092)	1
2	V	32	Interest	32	Peoria Real Estate	100.00%	582,117	582,085	2
3	V	19	Audit Fees		Peoria Real Estate	100.00%	4,100	4,100	3
4	V	19	Professional Fees		Peoria Real Estate	100.00%	883	883	4
5	V	21	Bank Charges		Peoria Real Estate	100.00%	15,525	15,525	5
6	V	33	Real Estate Tax		Peoria Real Estate	100.00%	101,067	101,067	6
7	V	30	Depreciation		Peoria Real Estate	100.00%	123,239	123,239	7
8	V	36	Amortization Loan Fee		Peoria Real Estate	100.00%	6,075	6,075	8
9	V	21	Base Admin Fee (Page 6A)		Peoria Real Estate	100.00%	7,200	7,200	9
10	V	26	Insurance Expense - Property		Peoria Real Estate	100.00%	8,980	8,980	10
11	V	36	Interest Exp-HUD MIP		Peoria Real Estate	100.00%	55,754	55,754	11
12	V								12
13	V								13
14	Total			$ 1,059,124			$ 904,940	$ * (154,184)	14

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

Facility Name & ID Number Rosewood Care Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	$	MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	$ 125	$ 125	15
16	V	6	MAINTENANCE EXPENSE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	76	76	16
17	V	19	PROFESSIONAL FEES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	91	91	17
18	V	20	DUES, SUBSCRIPTIONS, LICENSES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	1,844	1,844	18
19	V	21	OFFICE SALARIES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	96,290	96,290	19
20	V	21	OFFICE EXPENSES		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	25,986	25,986	20
21	V	24	SEMINAR		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	378	378	21
22	V	25	TRAVEL EXPENSE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	1,915	1,915	22
23	V	26	INSURANCE		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	3,319	3,319	23
24	V	27	EMPLOYEE BENEFITS		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	15,293	15,293	24
25	V	30	DEPRECIATION		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	12,528	12,528	25
26	V	32	INTEREST		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	14,336	14,336	26
27	V	34	BUILDING RENT		MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%	11,650	11,650	27
28	V								28
29	V	17	ADMINISTRATIVE FEE	191,434	MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%		(191,434)	29
30	V	21	ADMINISTRATIVE FEE (BLDG CO)	7,200	MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%		(7,200)	30
31	V	35	VEHICLE LEASE	9,920	MIDWEST ADMINISTRATIVE SERVICES, INC.	100.00%		(9,920)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 208,554			$ 183,832	$ * (24,722)	39

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

Facility Name & ID Number Rosewood Care Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

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 SALARY	$	BRAVO NURSING HOME SERVICES, INC.	100.00%	$ 367	$ 367	15
16	V	7	DIETARY BENEFITS		BRAVO NURSING HOME SERVICES, INC.	100.00%	39	39	16
17	V	10	CORPORATE RN SALARIES		BRAVO NURSING HOME SERVICES, INC.	100.00%	23,355	23,355	17
18	V	15	CORPORATE RN SALARIES BENEFITS		BRAVO NURSING HOME SERVICES, INC.	100.00%	2,284	2,284	18
19	V	17	ADMINISTRATIVE SALARIES		BRAVO NURSING HOME SERVICES, INC.	100.00%	36,082	36,082	19
20	V	19	PROFESSIONAL FEES		BRAVO NURSING HOME SERVICES, INC.	100.00%	66	66	20
21	V	20	DUES & SUBSCRIPTIONS		BRAVO NURSING HOME SERVICES, INC.	100.00%	2	2	21
22	V	21	OFFICE EXPENSES		BRAVO NURSING HOME SERVICES, INC.	100.00%	368	368	22
23	V	24	SEMINAR & LODGING EXPENSE		BRAVO NURSING HOME SERVICES, INC.	100.00%	134	134	23
24	V	25	AUTO EXPENSE		BRAVO NURSING HOME SERVICES, INC.	100.00%	2,421	2,421	24
25	V	27	ADMINISTRATIVE & OFFICE BENEFITS		BRAVO NURSING HOME SERVICES, INC.	100.00%	2,903	2,903	25
26	V	35	AUTO LEASE		BRAVO NURSING HOME SERVICES, INC.	100.00%	7	7	26
27	V								27
28	V	17	ADMINISTRATIVE FEE	138,000	BRAVO NURSING HOME SERVICES, INC.	100.00%		(138,000)	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			$ 138,000			$ 68,027	$ * (69,973)	39

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

Facility Name & ID Number Rosewood Care Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	CONSULTING FEES	$	BRAVO HOLDING COMPANY	100.00%	$ 5,642	$ 5,642	15
16	V	19	PROFESSIONAL FEES		BRAVO HOLDING COMPANY	100.00%	15,016	15,016	16
17	V	20	DUES & SUBSCRIPTIONS		BRAVO HOLDING COMPANY	100.00%	192	192	17
18	V	21	OFFICE EXPENSE		BRAVO HOLDING COMPANY	100.00%	260	260	18
19	V	24	SEMINAR EXPENSE		BRAVO HOLDING COMPANY	100.00%	232	232	19
20	V	25	AUTO & TRAVEL EXPENSE		BRAVO HOLDING COMPANY	100.00%	1,173	1,173	20
21	V	32	INTEREST		BRAVO HOLDING COMPANY	100.00%	(987)	(987)	21
22	V	35	AUTO RENTAL		BRAVO HOLDING COMPANY	100.00%	5	5	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			$			$ 21,533	$ * 21,533	39

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

Facility Name & ID Number Rosewood Care Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

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 FEES	$	CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	$ 1,231	$ 1,231	15
16	V	20	LICENSES		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	195	195	16
17	V	21	OFFICE SALARIES		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	42,555	42,555	17
18	V	21	OFFICE EXPENSE		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	900	900	18
19	V	24	SEMINAR		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	250	250	19
20	V	25	AUTO / TRAVEL EXPENSE		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	2,672	2,672	20
21	V	27	EMPLOYEE BENEFITS		CLAIMS ADMINISTRATION SERVICES, LLC	100.00%	2,558	2,558	21
22	V								22
23	V	19	PROFESSIONAL FEES	(19,031)	CLAIMS ADMINISTRATION SERVICES, LLC	100.00%		19,031	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			$ (19,031)			$ 50,361	$ * 69,392	39

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

Facility Name & ID Number Rosewood Care Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

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.	100.00%	$ 231	$ 231	15
16	V	6	MAINTENANCE SALARY		SENIOR LIVING SERVICES, INC.	100.00%	33,283	33,283	16
17	V	6	MAINTENANCE EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	3,377	3,377	17
18	V	7	MAINTENANCE BENEFITS		SENIOR LIVING SERVICES, INC.	100.00%	4,719	4,719	18
19	V	19	PROFESSIONAL FEES		SENIOR LIVING SERVICES, INC.	100.00%	112	112	19
20	V	20	LICENSES		SENIOR LIVING SERVICES, INC.	100.00%	107	107	20
21	V	21	OFFICE EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	406	406	21
22	V	25	AUTO / TRAVEL EXPENSE		SENIOR LIVING SERVICES, INC.	100.00%	2,759	2,759	22
23	V	26	INSURANCE		SENIOR LIVING SERVICES, INC.	100.00%	927	927	23
24	V	30	DEPRECIATION		SENIOR LIVING SERVICES, INC.	100.00%	1,034	1,034	24
25	V	35	AUTO LEASE		SENIOR LIVING SERVICES, INC.	100.00%	10	10	25
26	V	6	MAINTENANCE SUPPLIES		SENIOR LIVING SERVICES, INC.	100.00%	30	30	26
27	V								27
28	V	6	MAINTENANCE SERVICES	71,114	SENIOR LIVING SERVICES, INC.	100.00%		(71,114)	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			$ 71,114			$ 46,996	$ * (24,118)	39

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

Facility Name & ID Number Rosewood Care Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

VII. RELATED PARTIES (continued)

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

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

1 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								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			$			$	$ *	39

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

Facility Name & ID Number Rosewood Care Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

VII. RELATED PARTIES (continued)

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

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

1 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			$			$	$ 0	15
16	V							0	16
17	V							0	17
18	V							0	18
19	V							0	19
20	V							0	20
21	V							0	21
22	V							0	22
23	V							0	23
24	V							0	24
25	V							0	25
26	V							0	26
27	V							0	27
28	V							0	28
29	V							0	29
30	V							0	30
31	V							0	31
32	V							0	32
33	V							0	33
34	V							0	34
35	V							0	35
36	V							0	36
37	V							0	37
38	V							0	38
39	Total			$ 0			$ 0	$ * 0	39

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

Facility Name & ID Number Rosewood Care Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

VII. RELATED PARTIES (continued)

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

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

1 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			$			$	$ 0	15
16	V							0	16
17	V							0	17
18	V							0	18
19	V							0	19
20	V							0	20
21	V							0	21
22	V							0	22
23	V							0	23
24	V							0	24
25	V							0	25
26	V							0	26
27	V							0	27
28	V							0	28
29	V							0	29
30	V							0	30
31	V							0	31
32	V							0	32
33	V							0	33
34	V							0	34
35	V							0	35
36	V							0	36
37	V							0	37
38	V							0	38
39	Total			$ 0			$ 0	$ * 0	39

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

Facility Name & ID Number Rosewood Care Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

VII. RELATED PARTIES (continued)

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

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

1 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			$			$	$ 0	15
16	V							0	16
17	V							0	17
18	V							0	18
19	V							0	19
20	V							0	20
21	V							0	21
22	V							0	22
23	V							0	23
24	V							0	24
25	V							0	25
26	V							0	26
27	V							0	27
28	V							0	28
29	V							0	29
30	V							0	30
31	V							0	31
32	V							0	32
33	V							0	33
34	V							0	34
35	V							0	35
36	V							0	36
37	V							0	37
38	V							0	38
39	Total			$ 0			$ 0	$ * 0	39

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

Facility Name & ID Number Rosewood Care Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	Hinde Feiner	50.00%	Bravo Care of Alton, Inc.	Alton, IL	Peoria Real Estate		Lessor	1
2	Hillel Yampol	50.00%	Bravo Care of East Peoria, Inc.	East Peoria, IL	Bravo Administrative Services, Inc.	St. Louis, MO	Administration	2
3			Bravo Care of Edwardsville, Inc.	Edwardsville, IL	Bravo Holding Company, Inc.	St. Louis, MO	Holding Company	3
4			Bravo Care of Elgin, Inc.	Elgin, IL	Bravo Nursing Home Services, Inc.	St. Louis, MO	Management	4
5			Bravo Care of Galesburg, Inc.	Galesburg, IL	Bravo Team Health, Inc.	St. Louis, MO	Human Resources	5
6			Bravo Care of Inverness, Inc.	Inverness, IL	Claims Administration Services, LLC.	St. Louis, MO	Legal Services	6
7			Bravo Care of Joliet, Inc.	Joliet, IL	Senior Living Services, Inc.	St. Louis, MO	Building Services	7
8			Bravo Care of Moline, Inc.	Moline, IL	Midwest Administrative Services, Inc.	St. Louis, MO	Administration	8
9			Bravo Care of Northbrook, Inc.	Northbrook, IL	Bravo Care of Wood River, Inc.	Wood River, IL	Supportive Living Facility	9
10			Bravo Care of Rockford, Inc.	Rockford, IL	Rosewood Home Health Services, Inc.	Edwardsville, IL	Home Health	10
11			Bravo Care of St. Charles, Inc.	St. Charles, IL				11
12			Bravo Care of St. Louis, Inc.	St. Louis, MO				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

Facility Name & ID Number Rosewood Care Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

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								2
3								3
4								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

Facility Name & ID Number Rosewood Care Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	Hillel Yampol	Shareholder	Administrative	50.00%	See Attached	1.13	5.65%	Alloc. Salary	$ 1,280	17-7	1
2	Mark Yampol	Relative	Administrative	0	See Attached	1.13	5.65%	Alloc. Fees	5,642	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 6,922		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 Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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
2										2
3										3
4										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	TOTALS					$	$		$	25

Facility Name & ID Number Rosewood Care Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

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, IN
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	PAT. DAYS	463,927	14	$ 2,224	$	26,174	$ 125	1
2	6	MAINTENANCE EXPENSE	PAT. DAYS	463,927	14	1,345		26,174	76	2
3	19	PROFESSIONAL FEES	PAT. DAYS	463,927	14	1,614		26,174	91	3
4	20	DUES, SUBSCRIPTIONS, LICEN	PAT. DAYS	463,927	14	32,685		26,174	1,844	4
5	21	OFFICE SALARIES	PAT. DAYS	463,927	14	1,706,712	1,706,712	26,174	96,290	5
6	21	OFFICE EXPENSES	PAT. DAYS	463,927	14	460,588		26,174	25,986	6
7	24	SEMINAR	PAT. DAYS	463,927	14	6,706		26,174	378	7
8	25	TRAVEL EXPENSE	PAT. DAYS	463,927	14	33,946		26,174	1,915	8
9	26	INSURANCE	PAT. DAYS	463,927	14	58,834		26,174	3,319	9
10	27	EMPLOYEE BENEFITS	PAT. DAYS	463,927	14	271,068		26,174	15,293	10
11	30	DEPRECIATION	PAT. DAYS	463,927	14	222,055		26,174	12,528	11
12	32	INTEREST	PAT. DAYS	463,927	14	254,102		26,174	14,336	12
13	34	BUILDING RENT	PAT. DAYS	463,927	14	206,500		26,174	11,650	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					$ 3,258,379	$ 1,706,712		$ 183,831	25

Facility Name & ID Number Rosewood Care Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

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, 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 SALARY	PAT. DAYS	463,927	14	$ 6,505	$ 6,505	26,174	$ 367	1
2	7	DIETARY BENEFITS	PAT. DAYS	463,927	14	687		26,174	39	2
3	10	CORPORATE RN SALARIES	PAT. DAYS	463,927	14	413,960	413,960	26,174	23,355	3
4	15	CORPORATE RN SALARIES BE	PAT. DAYS	463,927	14	40,484		26,174	2,284	4
5	17	ADMINISTRATIVE SALARIES	PAT. DAYS	463,927	14	639,544	639,544	26,174	36,082	5
6	19	PROFESSIONAL FEES	PAT. DAYS	463,927	14	1,170		26,174	66	6
7	20	DUES & SUBSCRIPTIONS	PAT. DAYS	463,927	14	27		26,174	2	7
8	21	OFFICE EXPENSES	PAT. DAYS	463,927	14	6,517		26,174	368	8
9	24	SEMINAR & LODGING EXPEN	PAT. DAYS	463,927	14	2,370		26,174	134	9
10	25	AUTO EXPENSE	PAT. DAYS	463,927	14	42,910		26,174	2,421	10
11	27	ADMINISTRATIVE & OFFICE I	PAT. DAYS	463,927	14	51,458		26,174	2,903	11
12	35	AUTO LEASE	PAT. DAYS	463,927	14	133		26,174	7	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,205,766	$ 1,060,009		$ 68,028	25

Facility Name & ID Number Rosewood Care Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	17	CONSULTING FEES	PATIENT DAYS	463,927	14	$ 100,000	$	26,174	$ 5,642	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	463,927	14	266,160		26,174	15,016	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	463,927	14	3,410		26,174	192	3
4	21	OFFICE EXPENSE	PATIENT DAYS	463,927	14	4,609		26,174	260	4
5	24	SEMINAR EXPENSE	PATIENT DAYS	463,927	14	4,112		26,174	232	5
6	25	AUTO & TRAVEL EXPENSE	PATIENT DAYS	463,927	14	20,788		26,174	1,173	6
7	32	INTEREST	PATIENT DAYS	463,927	14	(17,495)		26,174	(987)	7
8	35	AUTO RENTAL	PATIENT DAYS	463,927	14	85		26,174	5	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					$ 381,668	$		$ 21,533	25

Facility Name & ID Number Rosewood Care Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

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 FEES	ACTUAL FEES	667,999	13	$ 6,309	$	130,346	$ 1,231	1
2	20	LICENSES	ACTUAL FEES	667,999	13	1,000		130,346	195	2
3	21	OFFICE SALARIES	ACTUAL FEES	667,999	13	218,085	218,085	130,346	42,555	3
4	21	OFFICE EXPENSE	ACTUAL FEES	667,999	13	4,612		130,346	900	4
5	24	SEMINAR	ACTUAL FEES	667,999	13	1,281		130,346	250	5
6	25	AUTO / TRAVEL EXPENSE	ACTUAL FEES	667,999	13	13,694		130,346	2,672	6
7	27	EMPLOYEE BENEFITS	ACTUAL FEES	667,999	13	13,112		130,346	2,558	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					$ 258,092	$ 218,085		$ 50,361	25

Facility Name & ID Number Rosewood Care Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	ACTUAL FEES	929,714	14	$ 3,017	$	71,114	$ 231	1
2	6	MAINTENANCE SALARY	ACTUAL FEES	929,714	14	435,123	435,123	71,114	33,283	2
3	6	MAINTENANCE EXPENSE	ACTUAL FEES	929,714	14	44,153		71,114	3,377	3
4	7	MAINTENANCE BENEFITS	ACTUAL FEES	929,714	14	61,694		71,114	4,719	4
5	19	PROFESSIONAL FEES	ACTUAL FEES	929,714	14	1,467		71,114	112	5
6	20	LICENSES	ACTUAL FEES	929,714	14	1,402		71,114	107	6
7	21	OFFICE EXPENSE	ACTUAL FEES	929,714	14	5,306		71,114	406	7
8	25	AUTO / TRAVEL EXPENSE	ACTUAL FEES	929,714	14	36,073		71,114	2,759	8
9	26	INSURANCE	ACTUAL FEES	929,714	14	12,121		71,114	927	9
10	30	DEPRECIATION	ACTUAL FEES	929,714	14	13,517		71,114	1,034	10
11	35	AUTO LEASE	ACTUAL FEES	929,714	14	135		71,114	10	11
12	6	MAINTENANCE SUPPLIES	DIRECT ALLOCATION		13	6,541			30	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					$ 620,549	$ 435,123		$ 46,995	25

Facility Name & ID Number Rosewood Care Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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
2										2
3										3
4										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	TOTALS					$	$		$	25

Facility Name & ID Number Rosewood Care Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$ 0	1
2									0	2
3									0	3
4									0	4
5									0	5
6									0	6
7									0	7
8									0	8
9									0	9
10									0	10
11									0	11
12									0	12
13									0	13
14									0	14
15									0	15
16									0	16
17									0	17
18									0	18
19									0	19
20									0	20
21									0	21
22									0	22
23									0	23
24									0	24
25	TOTALS					$ 0	$ 0		$ 0	25

Facility Name & ID Number Rosewood Care Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$ 0	1
2									0	2
3									0	3
4									0	4
5									0	5
6									0	6
7									0	7
8									0	8
9									0	9
10									0	10
11									0	11
12									0	12
13									0	13
14									0	14
15									0	15
16									0	16
17									0	17
18									0	18
19									0	19
20									0	20
21									0	21
22									0	22
23									0	23
24									0	24
25	TOTALS					$ 0	$ 0		$ 0	25

Facility Name & ID Number Rosewood Care Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$ 0	1
2									0	2
3									0	3
4									0	4
5									0	5
6									0	6
7									0	7
8									0	8
9									0	9
10									0	10
11									0	11
12									0	12
13									0	13
14									0	14
15									0	15
16									0	16
17									0	17
18									0	18
19									0	19
20									0	20
21									0	21
22									0	22
23									0	23
24									0	24
25	TOTALS					$ 0	$ 0		$ 0	25

Facility Name & ID Number Rosewood Care Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Berkadia		X	Mortgage	82,647.82	11/1/06	$ 12,422,200	$ 11,096,422	12/1/41	0.0525	$ 582,117	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MidCap		X	Line of Credit							101,535	6
7												7
8												8
9	TOTAL Facility Related				82647.82		$ 12,422,200	$ 11,096,422			$ 683,652	9
	B. Non-Facility Related*											
10	Interest Income - Bldg Co		X								(32)	10
11	Allocated from MAS	X									14,336	11
12	Bravo Holding Interest	X									(38,945)	12
13	See Supplemental Schedule										(987)	13
14	TOTAL Non-Facility Related						$	$			$ (25,628)	14
15	TOTALS (line 9+line14)						$ 12,422,200	$ 11,096,422			$ 658,024	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 55,754 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.)**

**** 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 Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15	Allocated from Bravo Holding C	X					$	$			$ (987)	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related										(987)	20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rosewood Care Center Of Peoria # 0049312 **Report Period Beginning:** 07/01/15 **Ending:** 06/30/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 101,243	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.)		$ 101,917	2
3. Under or (over) accrual (line 2 minus line 1).		$ 674	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 100,392	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.		$ 101,066	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	98,592	8
	2012	97,884	9
	2013	97,913	10
	2014	99,085	11
	2015	104,750	12

Accrual based on PY tax bill.

RE Taxes paid on Line 2 are the second installment of the 2014 tax bill and the first installment of the 2015 tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rosewood Care Center Of Peoria COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0049312

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-17-326-009	Long Term Care Property	$ 102,028.00	$ 102,028.00
2.	14-17-326-010	Long Term Care Property	$ 1,843.04	$ 1,843.04
3.	14-17-376-001	Long Term Care Property	$ 878.50	$ 878.50
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 104,749.54	$ 104,749.54

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rosewood Care Center Of Peoria COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0049312

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 0.00	$ 0.00

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 _____ 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

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. [ ] (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: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	7,343 Acres	1989	$ 874,484	1
2					2
3	TOTALS			$ 874,484	3

Facility Name & ID Number Rosewood Care Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	$ 2,829,643	$ 123,239	40	$ 70,741	$ (52,498)	$ 1,903,075	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Rosewood Care Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

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			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		862,590			30,596	30,596	541,911	67
68	Related Party Allocations (Pages 12H & 12I)								68
69	Financial Statement Depreciation			17,226			(17,226)		69
70	TOTAL (lines 4 thru 69)		$ 3,692,233	$ 140,465		$ 101,337	$ (39,128)	$ 2,444,986	70

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

Facility Name & ID Number Rosewood Care Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

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		$ 3,692,233	$ 140,465		$ 101,337	$ (39,128)	$ 2,444,986	1
2	Firestopping	2013	3,285		20	657	657	2,026	2
3	Install Floors Rm 404,406,407,408,409,410,411,412	2014	21,155		20	3,022	3,022	4,784	3
4	Wallpaper Rm 404,406,407,408,409,410,411,412	2014	4,300		20	614	614	972	4
5	Kitchen Impr-Sink Base, Repair Wall, Cove Base, New Cabinets,	2014	4,430		20	633	633	1,002	5
6	Cabinet Base, Counter Top & Sink, Replaced Plumbing	2014			20				6
7	Replace Compressor Scroll	2015	2,846		20	142	142	142	7
8	Repair Leaks In Attic	2016	7,846		20	392	392	392	8
9	Repair Generator	2016	7,058		20	353	353	353	9
10	Repair Fire Alarm Panel	2016	5,123		20	256	256	256	10
11	Replace Bearings On Cooling Tower; Fan Motor	2016	3,375		20	169	169	169	11
12	Replace Compressor Rotary	2016	2,599		20	130	130	130	12
13	Compressor Rotary, Thermostat, Pressure Control	2016	2,625		20	131	131	131	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)		$ 3,756,875	$ 140,465		$ 107,837	$ (32,628)	$ 2,455,344	34

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

Facility Name & ID Number Rosewood Care Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

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		$ 3,756,875	$ 140,465		$ 107,837	$ (32,628)	$ 2,455,344	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		$ 3,756,875	$ 140,465		$ 107,837	$ (32,628)	$ 2,455,344	34

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

Facility Name & ID Number Rosewood Care Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

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 12C, Carried Forward		$ 3,756,875	$ 140,465		$ 107,837	$ (32,628)	$ 2,455,344	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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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)		$ 3,756,875	$ 140,465		$ 107,837	$ (32,628)	$ 2,455,344	34

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

Facility Name & ID Number Rosewood Care Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

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 12D, Carried Forward		$ 3,756,875	$ 140,465		$ 107,837	$ (32,628)	$ 2,455,344	1
2									2
3									3
4									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)		$ 3,756,875	$ 140,465		$ 107,837	$ (32,628)	$ 2,455,344	34

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

Facility Name & ID Number Rosewood Care Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Paving, Sewers, Drains, Sidewalks, Curbs, Landscaping	1989	254,666		25			254,666	9
10	Walk-In Cooler	1989	5,770		10			5,770	10
11	Exhaust Hood	1989	4,620		10			4,620	11
12	Facility Signs	1989	2,826		10			2,826	12
13	Entry Concrete Slab	1990	6,197		25	248	248	6,156	13
14	Roof Valley	1991	4,140		40	104	104	2,580	14
15	Sign	1991	3,733		10			3,733	15
16	Irrigation System	1993	10,125		25	405	405	9,349	16
17	Parking Lot Expansion	1994	3,475		25	139	139	3,035	17
18	Parking Lot Expansion	1995	56,648		25	2,266	2,266	46,640	18
19	Irrigation System	1995	2,029		25	81	81	1,670	19
20	Parking Lot	1997	39,664		25	1,587	1,587	30,939	20
21	Parking Lot Sealing & Striping	2004	21,277		25	851	851	10,709	21
22	Roof	2005	89,412		40	2,235	2,235	24,215	22
23	Door Closures	2005	2,870		10	120	120	2,870	23
24	Console Heat Pumps	2006	6,337		10	422	422	6,337	24
25	Heat Pumps	2007	3,320		10	332	332	2,905	25
26	Cooling Tower	2008	50,686		10	5,069	5,069	40,972	26
27	Cooling Unit for Walk-In Cooler	2008	3,700		10	370	370	2,991	27
28	Seal & Stripe Parking Lot	2008	6,490		25	260	260	2,078	28
29	Cabinet / Countertops	2009	4,347		10	435	435	3,116	29
30	Telephone System	2009	30,716		10	3,072	3,072	22,014	30
31	Generator	2009	4,781		10	478	478	3,307	31
32	Sprinkler Pipe	2010	2,928		10	293	293	1,855	32
33	Asphalt Parking Lot	2010	61,200		25	2,448	2,448	14,484	33
34	TOTAL (lines 1 thru 33)		$ 681,957	$		$ 21,213	$ 21,213	$ 509,837	34

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

Facility Name & ID Number Rosewood Care Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

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 12F, Carried Forward		$ 681,957	$		$ 21,213	$ 21,213	$ 509,837	1
2	Sidewalks	2010	7,200		25	288	288	1,728	2
3	Water Heater	2011	3,016		10	302	302	1,509	3
4	Doors	2011	19,324		10	1,932	1,932	9,339	4
5	Replace Boiler	2012	7,842		10	784	784	3,518	5
6	Sprinkler	2012	3,830		10	383	383	1,596	6
7	Sidewalks	2012	5,239		25	210	210	787	7
8	Tuckpointing	2012	4,482		40	112	112	429	8
9	Shower Renovation-flooring,wall system,shower heads,handles,drains	2012	45,215		40	1,130	1,130	4,238	9
10	Water Filtration System	2013	3,997		40	100	100	325	10
11	HVAC Unit	2013	5,257		40	131	131	426	11
12	Sprinkler	2012	16,874		40	422	422	1,656	12
13	New HVAC Unit	2013	3,760		40	94	94	274	13
14	Door	2013	3,300		40	83	83	228	14
15	Grease Trap	2013	6,293		40	157	157	406	15
16	Boiler Pump	2013	2,700		10	270	270	810	16
17	Cooling Tower	2013	2,639		10	264	264	550	17
18	Fire Alarm Panel	2014	4,995		10	500	500	1,042	18
19	Sprinkler	2014	4,287		40	107	107	232	19
20	Seal Coating	2014	6,325		25	253	253	464	20
21	Repair Dry Pendant	2015	4,173		40	104	104	139	21
22	Install Console Units-Rm 404, 406, 407, 408, 409, 410, 411, 412	2015	9,515		10	952	952	1,428	22
23	Update Fire Alarm System - 400 Wing	2015	5,750		10	575	575	719	23
24	Fuel Tank	2016	4,620		10	231	231	231	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)		$ 862,590	$		$ 30,596	$ 30,596	$ 541,911	34

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

Facility Name & ID Number Rosewood Care Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	Related Party		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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
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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)		$	$		$	$	$	34

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

Facility Name & ID Number Rosewood Care Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

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 12H, Carried Forward		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		$	$		$	$	$	34

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

Facility Name & ID Number Rosewood Care Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	$ 449,396	$ 2,277	$ 36,953	$ 34,676	10	$ 357,626	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	13,119	97	97		10	13,119	73
74								74
75	TOTALS	$ 462,515	$ 2,374	$ 37,050	$ 34,676		$ 370,745	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		Allocated from MAS	various	$ 39,826	$ 10,154	$ 10,154	$	5	$ 25,885	76
77		Allocated from Senior Living Ser	various	11,449	1,034	1,034		5	10,713	77
78										78
79										79
80	TOTALS			$ 51,275	$ 11,188	$ 11,188	$		$ 36,598	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)	$ 5,145,149	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 154,027	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 156,076	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,049	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,862,687	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					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	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 Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	Offsite Storage				2,055			5
6	Allocated from MAS				11,650			6
7	TOTAL				$ 13,705 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Bravo Nursing Home		$	$ 7	17
18	Allocated from Bravo Holding Company			5	18
19	Allocated from Senior Living Services			10	19
20					20
21	TOTAL		$	$ 22	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 Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

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

   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 Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 367,907	$		$ 367,907	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			77,034			77,034	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			410,408			410,408	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				199,988		199,988	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					6,656	24,986		31,642	13
14	TOTAL			$		$ 862,005	$ 224,974		$ 1,086,979	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.

STATE OF ILLINOIS

Facility Name & ID Number Rosewood Care Center Of Peoria **#** 0049312 **Report Period Beginning:** 07/01/15 **Ending:** 06/30/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/16 **(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	$ 1,035	$ 1,533	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,476,714	1,476,714	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	43,729	47,097	6
7	Other Prepaid Expenses	1,216	231,434	7
8	Accounts Receivable (owners or related parties)	822,834	822,834	8
9	Other(specify): See Attached Schedule	2,000	102,987	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,347,528	$ 2,682,599	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		3,001,886	14
15	Leasehold Improvements, at Historical Cost	29,885	510,419	15
16	Equipment, at Historical Cost	64,786	631,998	16
17	Accumulated Depreciation (book methods)	(50,782)	(2,806,013)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 43,889	$ 2,212,774	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,391,417	$ 4,895,373	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,871,362	$ 1,929,889	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	98,315	98,315	30
31	Accrued Taxes Payable (excluding real estate taxes)	133,529	133,529	31
32	Accrued Real Estate Taxes(Sch.IX-B)		100,392	32
33	Accrued Interest Payable		653,773	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	10,512	24,422	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	1,780,174	225,552	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,893,892	$ 3,165,872	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,096,422	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)**	$	$ 11,096,422	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,893,892	$ 14,262,294	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,502,475)	$ (9,366,921)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,391,417	$ 4,895,373	48

***(See instructions.)**

Facility Name & ID Number Rosewood Care Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (518,632)	1
2	Restatements (describe):		2
3	**Prior Period Equity Adjustments**	(3,644)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (522,276)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(980,199)	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)**	$ (980,199)	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)**	$ (1,502,475)	24 *

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

Facility Name & ID Number Rosewood Care Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	$ 6,208,013	1
2	Discounts and Allowances for all Levels	(2,355,869)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,852,144	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,378,872	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,378,872	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	4,496	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	231,609	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	16,195	19
20	Radiology and X-Ray	8,930	20
21	Other Medical Services	88,183	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 350,613	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	38,945	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 38,945	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	7,467	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,467	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,628,041	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,369,503	31
32	Health Care	2,242,524	32
33	General Administration	1,411,326	33
	B. Capital Expense		
34	Ownership	1,210,690	34
	C. Ancillary Expense		
35	Special Cost Centers	1,178,370	35
36	Provider Participation Fee	195,827	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,608,240	40
41	**Income before Income Taxes (line 30 minus line 40)****	(980,199)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (980,199)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,833,285	44
45	Private Pay - Net Inpatient Revenue	1,282,186	45
46	Medicare - Net Inpatient Revenue	533,818	46
47	Other-(specify)	202,855	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,852,144	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.**

Facility Name & ID Number Rosewood Care Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	1,834	1,916	$ 70,980	$ 37.05	1
2	Assistant Director of Nursing	840	856	26,668	31.15	2
3	Registered Nurses	9,734	10,319	258,508	25.05	3
4	Licensed Practical Nurses	18,325	19,314	398,376	20.63	4
5	CNAs & Orderlies	57,440	60,729	725,597	11.95	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,434	4,715	65,672	13.93	8
9	Activity Director	2,080	2,232	40,740	18.25	9
10	Activity Assistants	4,007	4,558	38,487	8.44	10
11	Social Service Workers	3,921	4,021	41,115	10.23	11
12	Dietician					12
13	Food Service Supervisor	272	378	8,290	21.93	13
14	Head Cook					14
15	Cook Helpers/Assistants	2,078	2,846	29,063	10.21	15
16	Dishwashers					16
17	Maintenance Workers	2,304	2,497	43,689	17.50	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,080	2,128	71,684	33.69	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,381	8,876	91,421	10.30	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,173	2,329	25,912	11.13	31
32	Other Health Care(specify)					32
33	Other(specify)	4,111	4,353	88,141	20.25	33
34	TOTAL (lines 1 - 33)	124,014	132,067	$ 2,024,343 *	$ 15.33	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	$ 623	01-03	35
36	Medical Director	Monthly	18,100	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,455	10-03	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	2,000	11-03	44
45	Social Service Consultant	Monthly	2,200	12-03	45
46	Other(specify) Outsourced Dietary	Monthly	352,157	01-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 381,535		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	3,474	$ 137,053	10-03	50
51	Licensed Practical Nurses	4,210	161,225	10-03	51
52	Certified Nurse Assistants/Aides	317	7,498	10-03	52
53	TOTAL (lines 50 - 52)	8,001	$ 305,776		53

Facility Name & ID Number Rosewood Care Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Randi Lienhart	Administrator	0	$ 71,684
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 71,684

B. Administrative - Other

Description	Amount
Volume Admin Fee - Midwest Admin Services	$ 155,434
Base Management Fee - Bravo Nursing Home Services	138,000
Base Admin Fee - Midwest Admin Services	36,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 329,434
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Claims Administration Services	Related Party Legal	$ (19,031)
Infinite Solutions	IT Support	20,626
Larry Templin	Accounting	1,856
Various	Court Reporters	4,512
Timothy J. Slavin	Mediation	2,145
See Attached	Legal Fees	34,189
Westlaw	Reference Software	1,471
Marcum LLP	Accounting	1,466
Retirement Plan Associates	401K Consultants	44
Odessa Healthcare	Operations Consultant	39,323
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 86,602

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 52,614
Unemployment Compensation Insurance	40,580
FICA Taxes	151,151
Employee Health Insurance	30,635
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employer Relations	1,646
401K Expense	1,334
Employee Physcials & Drug Tests	1,687
TOTAL (agree to Schedule V, line 22, col.8)	$ 279,647

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	775
Health Care Worker Background Check	
(Indicate # of checks performed 245)	2,455
Patient Background Checks	
Dues & Subscriptions	4,346
Allocated from MAS	1,844
Allocated from Bravo Nursing Home	2
Allocated from Bravo Holding Company	192
See Supplemental Schedule	302
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,896

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,749
Allocated from MAS	378
Allocated from Bravo Nursing Home	134
See Supplemental Schedule	482
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,743

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Rosewood Care Center Of Peoria # 0049312 Report Period Beginning: 07/01/15 Ending: 06/30/16

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $6,869**

(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? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **46,294** 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. $ **195,827**
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. $ Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **4,496**

(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? **100% Ln 14**
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