

Facility Name & ID Number Mid America Care Center, Llc

0047035 Report Period Beginning: 01/01/12 Ending: 12/31/12

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>310</u>	Skilled (SNF)	<u>310</u>	<u>113,460</u>	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	<u>310</u>	TOTALS	<u>310</u>	<u>113,460</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>53,739</u>	<u>1,319</u>	<u>7,614</u>	<u>62,672</u>	8
9	SNF/PED					9
10	ICF	<u>33,787</u>			<u>33,787</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>87,526</u>	<u>1,319</u>	<u>7,614</u>	<u>96,459</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.02%

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 ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☒ NO ☐

I. On what date did you start providing long term care at this location? Date started 1975

J. Was the facility purchased or leased after January 1, 1978? YES ☐ Date NO ☒

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 310 and days of care provided 6,328

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Mid America Care Center, Llc

0047035

Report Period Beginning:

01/01/12

Ending:

12/31/12

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					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	461,481	109,843	14,799	586,123		586,123	70	586,193		1
2	Food Purchase		627,857		627,857	(63,904)	563,953	(2,516)	561,437		2
3	Housekeeping	472,012	80,898		552,910		552,910	3,780	556,690		3
4	Laundry	215,310	13,369	3,097	231,776		231,776		231,776		4
5	Heat and Other Utilities			262,907	262,907		262,907	(3,796)	259,111		5
6	Maintenance	129,744	47,143	102,984	279,871		279,871	33,410	313,281		6
7	Other (specify):*										7
8	TOTAL General Services	1,278,547	879,110	383,787	2,541,444	(63,904)	2,477,540	30,948	2,508,488		8
	B. Health Care and Programs										
9	Medical Director			81,300	81,300		81,300	14,183	95,483		9
10	Nursing and Medical Records	3,738,396	254,565	35,969	4,028,930		4,028,930	(136)	4,028,794		10
10a	Therapy	299,705		119,971	419,676		419,676		419,676		10a
11	Activities	204,259	15,801	798	220,858		220,858		220,858		11
12	Social Services	295,400			295,400		295,400		295,400		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,537,760	270,366	238,038	5,046,164		5,046,164	14,047	5,060,211		16
	C. General Administration										
17	Administrative	267,438		458,124	725,562		725,562	(194,798)	530,764		17
18	Directors Fees										18
19	Professional Services			1,591,008	1,591,008	(225)	1,590,783	(1,541,301)	49,482		19
20	Dues, Fees, Subscriptions & Promotions			247,827	247,827		247,827	(193,511)	54,316		20
21	Clerical & General Office Expenses	362,752	37,896	443,753	844,401		844,401	(146,512)	697,889		21
22	Employee Benefits & Payroll Taxes			1,176,000	1,176,000	63,904	1,239,904		1,239,904		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,415	5,415		5,415	(2,971)	2,444		24
25	Other Admin. Staff Transportation			5,168	5,168		5,168	91	5,259		25
26	Insurance-Prop.Liab.Malpractice			261,105	261,105		261,105	13,279	274,384		26
27	Other (specify):*							94,812	94,812		27
28	TOTAL General Administration	630,190	37,896	4,188,400	4,856,486	63,679	4,920,165	(1,970,911)	2,949,254		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,446,497	1,187,372	4,810,225	12,444,094	(225)	12,443,869	(1,925,916)	10,517,953		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			248,356	248,356		248,356	38,599	286,955			30
31	Amortization of Pre-Op. & Org.			4,313	4,313		4,313		4,313			31
32	Interest			264,995	264,995		264,995	(85,136)	179,859			32
33	Real Estate Taxes					225	225	292,402	292,627			33
34	Rent-Facility & Grounds			1,110,000	1,110,000		1,110,000	(1,110,000)				34
35	Rent-Equipment & Vehicles			8,227	8,227		8,227	(7,390)	837			35
36	Other (specify):*											36
37	TOTAL Ownership			1,635,891	1,635,891	225	1,636,116	(871,525)	764,591			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		285,058	955,054	1,240,112		1,240,112		1,240,112			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			717,285	717,285		717,285		717,285			42
43	Other (specify):*	270,870		8,992	279,862		279,862	(279,862)				43
44	TOTAL Special Cost Centers	270,870	285,058	1,681,331	2,237,259		2,237,259	(279,862)	1,957,397			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,717,367	1,472,430	8,127,447	16,317,244		16,317,244	(3,077,304)	13,239,940			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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
5	Telephone, TV & Radio in Resident Rooms	(10,066)	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	(49,398)	30		9
10	Interest and Other Investment Income	(316,824)	32		10
11	Discounts, Allowances, Rebates & Refunds	(3,598)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(85)	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	(574)	21		18
19	Entertainment				19
20	Contributions	(142,325)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(360,588)	21		24
25	Fund Raising, Advertising and Promotional	(42,918)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,365,781)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,292,158)		\$	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)	(785,146)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (785,146)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (3,077,304)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Report Period Beginning:

Ending:

ID#

0047035

01/01/12

12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Bank Charges	\$ (4,640)	21	1
2	Marketing Salary	(270,870)	43	2
3	Theft & Loss	(1,533)	21	3
4	Vending Income	(2,431)	02	4
5	Non-Allowable Accounting Fee	(5,000)	19	5
6	Marketing Consultant	(8,992)	43	6
7	COPE Dues	(13,332)	20	7
8	Building 4930 Real Estate Tax Expense	(7,396)	33	8
9	Non-Allowable Auto Lease	(8,227)	35	9
10	Collections Expense	(8,461)	21	10
11	Non-Allowable Seminar	(3,810)	24	11
12	Non-Allowable Travel	(339)	25	12
13	Capitalized R&M	(1,840)	06	13
14	Non-Allowable Legal	(1,601)	19	14
15	Building Company Prior Period Expense	(513)	21	15
16	Building Company Amortization	(14,386)	31	16
17	Building Company License & Permits	(175)	20	17
18	Building Company Office Expense	(606)	21	18
19	Building Company Professional Fees	(21,200)	19	19
20	Building Company Contributions	(1,000,000)	20	20
21	Additional R&M	9,709	06	21
22	Prior Period Insurance Expense	(2)	26	22
23	Jury Duty Income	(136)	10	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	(1,365,781)		49

ID#0047035

Report Period Beginning:01/01/12

Ending:12/31/12

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			49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent Income	\$ 1,110,000	Mid America Convalescent Center, Inc.	100.00%	\$	\$ (1,110,000)	1
2	V	21	Miscellaneous Income	20	Mid America Convalescent Center, Inc.	100.00%		(20)	2
3	V	32	Interest	352,701	Mid America Convalescent Center, Inc.	100.00%	574,119	221,418	3
4	V	21	Prior Period Adjustment		Mid America Convalescent Center, Inc.	100.00%	513	513	4
5	V	31	Amortization		Mid America Convalescent Center, Inc.	100.00%	14,386	14,386	5
6	V	33	Real Estate Taxes		Mid America Convalescent Center, Inc.	100.00%	292,058	292,058	6
7	V	20	Licenses & Permits		Mid America Convalescent Center, Inc.	100.00%	175	175	7
8	V	21	Office Expenses		Mid America Convalescent Center, Inc.	100.00%	606	606	8
9	V	26	Multiperil Insurance		Mid America Convalescent Center, Inc.	100.00%	12,836	12,836	9
10	V	19	Professional Fees		Mid America Convalescent Center, Inc.	100.00%	21,200	21,200	10
11	V	05	Utilities		Mid America Convalescent Center, Inc.	100.00%	3,347	3,347	11
12	V	30	Depreciation		Mid America Convalescent Center, Inc.	100.00%	33,594	33,594	12
13	V	20	Contributions		Mid America Convalescent Center, Inc.	100.00%	1,000,000	1,000,000	13
14	Total			\$ 1,462,721			\$ 1,952,834	\$ * 490,113	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	\$	MANAGCARE, INC.	100.00%	\$ 70	\$ 70	15
16	V	3	HOUSEKEEPING		MANAGCARE, INC.	100.00%	3,780	3,780	16
17	V	5	UTILITIES		MANAGCARE, INC.	100.00%	2,923	2,923	17
18	V	6	REPAIRS AND MAINT.		MANAGCARE, INC.	100.00%	25,541	25,541	18
19	V	9	MEDICAL DIRECTOR		MANAGCARE, INC.	100.00%	14,183	14,183	19
20	V	17	ADMINISTRATIVE		MANAGCARE, INC.	100.00%	250,645	250,645	20
21	V	19	PROFESSIONAL FEES		MANAGCARE, INC.	100.00%			21
22	V	20	FEES, SUBSCRIPTIONS		MANAGCARE, INC.	100.00%	5,021	5,021	22
23	V	21	CLERICAL AND GENERAL		MANAGCARE, INC.	100.00%	232,883	232,883	23
24	V	24	SEMINARS		MANAGCARE, INC.	100.00%	839	839	24
25	V	25	ADMIN. STAFF TRANS.		MANAGCARE, INC.	100.00%	430	430	25
26	V	26	INSURANCE		MANAGCARE, INC.	100.00%	445	445	26
27	V	27	GEN. ADMIN. EMP. BEN.		MANAGCARE, INC.	100.00%	93,846	93,846	27
28	V	30	DEPRECIATION		MANAGCARE, INC.	100.00%	47,515	47,515	28
29	V	32	INTEREST EXPENSE		MANAGCARE, INC.	100.00%	1,050	1,050	29
30	V	34	RENT - BUILDING (RELATED)		MANAGCARE, INC.	100.00%	30,108	30,108	30
31	V	35	EQUIPMENT RENTAL		MANAGCARE, INC.	100.00%	837	837	31
32	V								32
33	V	19	BOOKKEEPING	1,534,960				(1,534,960)	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 1,534,960			\$ 710,116	\$ * (824,844)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	\$	INTERCARE, LTD. C/O MANAGCARE	100.00%	\$ 12,681	\$ 12,681	15
16	V	19	PROFESSIONAL FEES		INTERCARE, LTD. C/O MANAGCARE	100.00%			16
17	V	20	FEES, SUBSCRIPTIONS		INTERCARE, LTD. C/O MANAGCARE	100.00%	43	43	17
18	V	21	CLERICAL & GENERAL		INTERCARE, LTD. C/O MANAGCARE	100.00%	19	19	18
19	V	27	EMPLOYEE BENEFITS		INTERCARE, LTD. C/O MANAGCARE	100.00%	966	966	19
20	V	30	DEPRECIATION		INTERCARE, LTD. C/O MANAGCARE	100.00%			20
21	V	32	INVESTMENT		INTERCARE, LTD. C/O MANAGCARE	100.00%			21
22	V	35	EQUIPMENT RENTAL		INTERCARE, LTD. C/O MANAGCARE	100.00%			22
23	V								23
24	V	17	MANAGEMENT FEES	458,124	INTERCARE, LTD. C/O MANAGCARE	100.00%		(458,124)	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			\$ 458,124			\$ 13,709	\$ * (444,415)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	\$	4600 TOUHY, LLC	100.00%	\$	\$	15
16	V	5	UTILITIES		4600 TOUHY, LLC				16
17	V	6	REPAIRS & MAINT.		4600 TOUHY, LLC				17
18	V	17	ADMIN.-M. WOLF		4600 TOUHY, LLC				18
19	V	19	PROFESSIONAL FEES		4600 TOUHY, LLC		260	260	19
20	V	20	FEES, SUBSCRIPTIONS		4600 TOUHY, LLC				20
21	V	21	CLERICAL & GENERAL		4600 TOUHY, LLC				21
22	V	26	INSURANCE		4600 TOUHY, LLC				22
23	V	30	DEPRECIATION		4600 TOUHY, LLC		6,888	6,888	23
24	V	32	INTEREST EXPENSE		4600 TOUHY, LLC		9,220	9,220	24
25	V	33	REAL ESTATE TAXES		4600 TOUHY, LLC		7,740	7,740	25
26	V								26
27	V								27
28	V								28
29	V	34	RENT	30,108	4600 TOUHY, LLC			(30,108)	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			\$ 30,108			\$ 24,108	\$ * (6,000)	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	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

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	AHUVA WEINREB	0.590%	BRIGHTVIEW CARE CENTER, INC	CHICAGO	MID AMERICA CONVALESCENT CENTER, INC.		BUILDING CO.	1
2	DAVIS FAMILY TRUST	35.918%	LAKE SHORE HEALTHCARE & REHABILITATION CENTRE,LLC	CHICAGO	4600 Touhy LLC		BUILDING CO.	2
3	EDIE DAVIS	0.672%	MAYFIELD CARE CENTER, INC.	CHICAGO	MANAGCARE, INC.		MANAGEMENT CO.	3
4	ELIYAHU DAVIS	0.590%			INTERCARE, LTD. C/O MANAGCARE		MANAGEMENT CO.	4
5	MOSHE Y. DAVIS	0.590%						5
6	NESANEL B. DAVIS	0.590%						6
7	SHOSHANA BRAUN	0.590%						7
8	YEHOSHUA B. DAVIS	0.590%						8
9	YISROEL M. DAVIS	0.590%						9
10	YOSEF DAVIS	0.059%						10
11	YOSEF DAVIS DELTA TRUST	59.221%						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

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

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Davis	Shareholder	Administrative	0.059%	See Attached	9.13	30.43%	Alloc. Salary	\$ 12,681	17-7	1
2	Yehoshua Davis	Shareholder	Administrative	0.590%	See Attached	46	95.83%	Sal/Al. Sal	198,464	17-1;17-1	2
3											3
4											4
5											5
6											6
7	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only amounts anticipated to be considered allowable by the										7
8	IL Dept of HFS.										8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 211,145		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 Mid America Care Center, Llc # 0047035 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
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 Mid America Care Center, Llc # 0047035 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 MANAGCARE, INC.
Street Address 4600 W. TOUHY AVENUE, SUITE 200
City / State / Zip Code LINCOLNWOOD, IL 60712
Phone Number (773) 463-1313
Fax Number (773) 463- 5311

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	DIETARY	PATIENT DAYS	278,486	4	\$ 201	\$	96,459	\$ 70	1
2	3	HOUSEKEEPING	PATIENT DAYS	278,486	4	10,914		96,459	3,780	2
3	5	UTILITIES	PATIENT DAYS	278,486	4	8,439		96,459	2,923	3
4	6	REPAIRS AND MAINT.	PATIENT DAYS	278,486	4	73,740		96,459	25,541	4
5	9	MEDICAL DIRECTOR	PATIENT DAYS	278,486	4	40,948		96,459	14,183	5
6	17	ADMINISTRATIVE	PATIENT DAYS	278,486	4	723,635	723,635	96,459	250,645	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	278,486	4			96,459		7
8	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	278,486	4	14,497		96,459	5,021	8
9	21	CLERICAL AND GENERAL	PATIENT DAYS	278,486	4	672,355	453,150	96,459	232,883	9
10	24	SEMINARS	PATIENT DAYS	278,486	4	2,422		96,459	839	10
11	25	ADMIN. STAFF TRANS.	PATIENT DAYS	278,486	4	1,240		96,459	430	11
12	26	INSURANCE	PATIENT DAYS	278,486	4	1,286		96,459	445	12
13	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	278,486	4	270,942		96,459	93,846	13
14	30	DEPRECIATION	PATIENT DAYS	278,486	4	137,181		96,459	47,515	14
15	32	INTEREST EXPENSE	PATIENT DAYS	278,486	4	3,032		96,459	1,050	15
16	34	RENT - BUILDING (RELATED)	PATIENT DAYS	278,486	4	86,925		96,459	30,108	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	278,486	4	2,412		96,459	837	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,050,169	\$ 1,176,785		\$ 710,116	25

Facility Name & ID Number Mid America Care Center, Llc # 0047035 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 INTERCARE, LTD. C/O MANAGCARE
Street Address 4600 W. TOUHY AVENUE, SUITE 200
City / State / Zip Code LINCOLNWOOD, IL 60712
Phone Number (773) 463-1313
Fax Number (773) 463- 5311

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	17	ADMINISTRATIVE	AVG. HOURS WORKED	18	4	\$ 25,000	\$ 25,000	9	\$ 12,681	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	18	4			9		2
3	20	FEES, SUBSCRIPTIONS	AVG. HOURS WORKED	18	4	85		9	43	3
4	21	CLERICAL & GENERAL	AVG. HOURS WORKED	18	4	38		9	19	4
5	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	18	4	1,905		9	966	5
6	30	DEPRECIATION	AVG. HOURS WORKED	18	4			9		6
7	32	INVESTMENT	AVG. HOURS WORKED	18	4			9		7
8	35	EQUIPMENT RENTAL	AVG. HOURS WORKED	18	4			9		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					\$ 27,028	\$ 25,000		\$ 13,709	25

Ending: 12/31/12

(773) 463- 5311

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center, Llc # 0047035 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
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 Mid America Care Center, Llc # 0047035 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
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 Mid America Care Center, Llc # 0047035 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
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 Mid America Care Center, Llc # 0047035 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
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 Mid America Care Center, Llc # 0047035 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
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 Mid America Care Center, Llc # 0047035 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
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

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	MB Financial		X	Mortgage			\$	4,900,000			\$	1	
2	MB Financial		X	Mortgage				14,000,000			574,119	2	
3												3	
4												4	
5	See Supplemental Schedule											5	
	Working Capital												
6	MB Financial		X	Line of Credit				2,273,000			95,482	6	
7	Volkswagon Financial		X	Auto Financing				6,690				7	
8	See Supplemental Schedule							5,018			10,270	8	
9	TOTAL Facility Related						\$	21,184,708			\$ 679,871	9	
	B. Non-Facility Related*												
10	Interest Income		X								(316,824)	10	
11	Interest Income- Bldg. Co.		X								(352,701)	11	
12	Misc. Interest Expense		X								169,513	12	
13	See Supplemental Schedule											13	
14	TOTAL Non-Facility Related						\$				\$ (500,012)	14	
15	TOTALS (line 9+line14)						\$	21,184,708			\$ 179,859	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* 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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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	Allocated From Managcare		X				\$		\$			\$					1,050		8
9	Allocated From 4600 Touhy		X														9,220		9
10	GMAC		X	Financing							5,018								10
11																			11
12																			12
13																			13
14	TOTAL Working Capital										5,018						10,270		14
	B. Non-Facility Related*																		
15							\$		\$			\$							15
16																			16
17																			17
18																			18
19																			19
20	TOTAL Non-Facility Related																		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.)

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2011 report.		\$	301,100	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.)		\$	294,002	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(7,098)	3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	299,500	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.		\$	225	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.		\$	292,627	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	312,099	8	
		2008	315,230	9	
		2009	275,465	10	
		2010	287,457	11	
		2011	286,262	12	
2012 Accrual = \$286,262 X 1.04 = \$299,500 (Rounded)					
Allocation From 4600 Touhy LLC: \$7740					

FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$	16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

FACILITY NAME Mid America Care Center, Llc COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0047035

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (____) _____ FAX #: (____) _____

Enter the tax index number and real estate tax assessed for 2011 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 2011.

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: 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. 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 Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAMEMid America Care Center, LlcCOUNTYCook

FACILITY IDPH LICENSE NUMBER0047035

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ()FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 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 2000.

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

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 & 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

94,500

B. General Construction Type:

Exterior

Frame

Number of Stories

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

21,565

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

5

3. Current Period Amortization:

4,312

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	94,500	1979	\$ 307,874	1
2	Allocated From 4600 Touhy LLC			20,782	2
3	TOTALS	94,500		\$ 328,656	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center, Llc

0047035

Report Period Beginning:

01/01/12

Ending:

12/31/12

XI. OWNERSHIP COSTS (continued)

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

	1		2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4	310			1975	\$ 3,258,613	\$ 5,890		\$	(5,890)	\$ 3,258,613	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	Various			1978	2,575		20			2,575	9	
10	Various			1979	33,995		20			33,995	10	
11	Various			1980	13,673		20			13,673	11	
12	Various			1981	107,932		20			107,932	12	
13	Various			1982	4,750		20			4,750	13	
14	Various			1983	1,787		20			1,787	14	
15	Various			1984	25,291		20			25,042	15	
16	Various			1985	17,828		20			17,679	16	
17	Various			1986	62,698		20			62,650	17	
18	Various			1987	18,422		20	157	157	18,382	18	
19	Various			1988	33,825		20	1,353	1,353	33,450	19	
20	Various			1989	23,916		20	226	226	23,526	20	
21	Various			1990	23,550		20			23,550	21	
22	Various			1991	20,020		20			11,918	22	
23	Various			1992	51,260		20	866	866	50,421	23	
24	Various			1993	7,134		20	252	252	7,095	24	
25	Various			1994	32,273		20	1,614	1,614	29,474	25	
26	Various			1995	227,831		20	11,236	11,236	199,951	26	
27	Various			1996	136,732		20	6,836	6,836	113,295	27	
28	Various			1997	26,804		20	1,340	1,340	20,824	28	
29	Various			1998	81,506		20	4,075	4,075	58,912	29	
30	Various			1999	113,499		20	5,675	5,675	76,753	30	
31	Various			2000	308,605		20	15,262	15,262	194,314	31	
32	Various			2001	56,517		20	2,826	2,826	32,542	32	
33	Various			2002	66,827		20	1,718	1,718	59,272	33	
34	Various			2003	33,074		20	2,693	2,693	25,872	34	
35	Various			2004	12,735		20	753	753	7,603	35	
36	Various			2005	13,227		20	1,213		8,676	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

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	Various	2006	\$ 34,488	\$	20	\$ 2,683	\$ 2,683	\$ 17,884	37
38	Various	2007	118,844		20	11,382	11,382	73,341	38
39	Various	2008	127,264		20	11,198	11,198	47,126	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)								67
68	Related Party Allocations (Pages 12H & 12I)		428,042	19,893		13,080	(6,813)	14,237	68
69	Financial Statement Depreciation			154,396			(154,396)		69
70	TOTAL (lines 4 thru 69)		\$ 5,525,538	\$ 180,179		\$ 96,437	\$ (84,955)	\$ 4,677,114	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mid America Care Center, Llc

0047035

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,525,538	\$ 180,179		\$ 96,437	\$ (83,742)	\$ 4,677,114	1
2	Walls/Cove Bases/Tiling/Floors/Walls	2009	141,854		20	14,185	14,185	43,738	2
3	Repaired Expansion Tank	2009	4,470		20	447	447	1,378	3
4	Walls/Covebase/Handrails/Ceiling/Lighting	2009	69,292		20	6,929	6,929	21,365	4
5	Electrical Work	2009	6,300		20	315	315	1,575	5
6	Remote Annunciator/Conduit/Electrical	2009	5,233		20	262	262	1,309	6
7	A/C Compressor	2009	18,680		20	934	934	3,736	7
8	Oem Expansion Valve Assem	2009	4,808		20	240	240	961	8
9	Rebuild Front Canopy	2009	4,700		20	235	235	940	9
10	Front Entry Roof	2009	3,600		20	180	180	720	10
11	Kitchen Door	2009	3,010		20	151	151	603	11
12	New Boiler Tubes	2009	13,500		20	675	675	2,700	12
13	4 Wanderguard Units	2009	6,831		20	342	342	1,367	13
14	Drive Way Wall Repair	2009	9,700		20	485	485	1,940	14
15	Doors	2009	11,390		20	570	570	2,279	15
16	Blinds/Cove/Handrails/Flooring	2009	58,803		20	2,940	2,940	11,760	16
17	2-5000 Watt Recessed Heaters	2009	11,250		20	563	563	2,251	17
18	Wanderguard Signalling Device/Alert System	2009	3,653		20	183	183	731	18
19	Air Conditioning Repair	2009	4,093		20	205	205	819	19
20	Exhaust Manifold	2010	3,162		20	158	158	422	20
21	Sprinkler System Repair	2010	3,653		20	183	183	396	21
22	5Th Floor Corridor: Cove Base And Handrail Installation. Reside	2010	66,261		20	3,313	3,313	6,902	22
23	Epoxy Quartz Flooring	2011	22,000		20	1,467	1,467	2,689	23
24	Aluminum Double Hung Windows	2011	191,328		20	19,133	19,133	30,294	24
25	Custom Shaped Canopy	2011	6,080		20	1,216	1,216	1,824	25
26	Fire Rated Access Doors	2011	3,527		20	353	353	500	26
27	Custom Sign	2011	5,651		20	565	565	753	27
28	Elevator Wraps	2011	7,608		20	380	380	697	28
29	Galvanized Piping	2011	8,750		20	875	875	1,677	29
30	Kitchen Dish Room Flooring	2012	4,900		20	327	327	327	30
31	Install Footings	2012	7,500		20	750	750	750	31
32	Roof Patching And Wall Flashing	2012	3,200		20	213	213	213	32
33	Install Emergency Generator	2012	221,840		20	5,500	5,500	5,500	33
34	TOTAL (lines 1 thru 33)		\$ 6,462,164	\$ 180,179		\$ 160,708	\$ (19,471)	\$ 4,830,228	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 6,462,164	\$ 180,179		\$ 160,708	\$ (19,471)	\$ 4,830,228	1
2	Asphalt Surface Sealing	2012	3,170		20	132	132	132	2
3	Repair Water Chiller	2012	5,944		20	396	396	396	3
4	4Th Fl Dayroom- Wallcovering, Painting, Window Treatments	2012	6,784		20	1,225	1,225	1,225	4
5	4Th Fl Dayroom: Wallcoverings, Handrails, Bump Guards, Window Trmts.	2012	162,781		20	10,852	10,852	10,852	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,640,843	\$ 180,179		\$ 173,314	\$ (6,865)	\$ 4,842,833	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 6,640,843	\$ 180,179		\$ 173,314	\$ (6,865)	\$ 4,842,833	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,640,843	\$ 180,179		\$ 173,314	\$ (6,865)	\$ 4,842,833	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 6,640,843	\$ 180,179		\$ 173,314	\$ (6,865)	\$ 4,842,833	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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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,640,843	\$ 180,179		\$ 173,314	\$ (6,865)	\$ 4,842,833	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Building Company Information								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
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Building Company Information Continued		\$	\$		\$	\$	\$	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 (12F & 12G lines 1 thru 33)		\$	\$		\$	\$	\$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated From 4600 Touhy LLC	2012	177,846	1,618	30	5,928	4,310	5,928	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated From Managcare	2012	37,131	13,004	20	1,769	(11,235)	1,769	9
10									10
11	Allocated From 4600 Touhy LLC	2012	210,826	5,271	20	5,271		5,271	11
12									12
13	Allocated From Intercare	2001	2,239		20	112	112	1,269	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party Information Continued								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 (12H & 12I lines 1 thru 33)		\$428,042	\$19,893		\$13,080	\$(6,813)	\$14,237	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$878,336	\$99,169	\$86,228	\$(12,941)	10	\$530,555	71
72	Current Year Purchases	295,972	46,060	16,694	(29,366)	10	16,694	72
73	Fully Depreciated Assets	1,065,044		55	55	10	1,064,874	73
74								74
75	TOTALS	\$2,239,351	\$145,229	\$102,977	\$(42,252)		\$1,612,122	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	Facility	2010 Volkswagen Tiguan	2010	\$22,507	\$4,017	\$4,017	\$0	5	\$13,133	76
77	Facility	Allocated From Managcare	2012	48,480	6,929	6,648	(281)	5	33,567	77
78										78
79										79
80	TOTALS			\$70,987	\$10,946	\$10,665	\$(281)		\$46,700	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$9,279,838	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$336,354	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$286,956	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(49,398)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$6,501,655	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	1994 ALTIMA - 1994	\$17,799	\$	\$	86
87	4930 BLDG - 1998	159,035			87
88	4930 LAND - 1998	17,500			88
89					89
90					90
91	TOTALS	\$194,334	\$	\$	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			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:
- *

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: \$837
- Description: See Attached Schedule

(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			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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.

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

☒ 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

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

		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)	\$			

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

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

		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	\$		\$ 371,610	\$		\$ 371,610	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			44,978			44,978	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			367,175			367,175	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				242,973		242,973	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					171,291	42,085		213,376	13
14	TOTAL			\$		\$ 955,054	\$ 285,058		\$ 1,240,112	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 556,932	\$ 828,952	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,114,935	4,149,877	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	252,863	262,916	6
7	Other Prepaid Expenses	32,018	32,018	7
8	Accounts Receivable (owners or related parties)		15,461,049	8
9	Other(specify): See Attached Schedule	3,739,634	3,890,195	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 8,696,382	\$ 24,625,007	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		325,374	13
14	Buildings, at Historical Cost		3,417,648	14
15	Leasehold Improvements, at Historical Cost	1,568,786	3,054,523	15
16	Equipment, at Historical Cost	962,270	2,222,289	16
17	Accumulated Depreciation (book methods)	(843,782)	(6,287,768)	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): See Attached Schedule	19,569	1,095,834	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,706,843	\$ 3,827,900	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,403,225	\$ 28,452,907	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 247,288	\$ 262,280	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	59,083	59,083	28
29	Short-Term Notes Payable	2,284,708	2,284,708	29
30	Accrued Salaries Payable	367,121	367,121	30
31	Accrued Taxes Payable (excluding real estate taxes)	93,337	93,337	31
32	Accrued Real Estate Taxes(Sch.IX-B)		299,500	32
33	Accrued Interest Payable	10,371	35,029	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	3,337,063	3,537,678	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,398,971	\$ 6,938,736	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		4,900,000	39
40	Mortgage Payable		14,000,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 18,900,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,398,971	\$ 25,838,736	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,004,254	\$ 2,614,171	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,403,225	\$ 28,452,907	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,894,962	1
2	Restatements (describe):		2
3	Rounding Adjustment	3	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,894,965	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	959,250	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	(1,849,961)	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)	\$ (890,711)	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)	\$ 4,004,254	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$17,766,194	1
2	Discounts and Allowances for all Levels	(2,760,869)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$15,005,325	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,586,599	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$1,586,599	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		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	264,476	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	20,141	19
20	Radiology and X-Ray	8,835	20
21	Other Medical Services	60,429	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$353,881	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	316,824	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$316,824	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	13,865	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$13,865	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$17,276,494	30

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,541,444	31
32	Health Care	5,046,164	32
33	General Administration	4,856,486	33
	B. Capital Expense		
34	Ownership	1,635,891	34
	C. Ancillary Expense		
35	Special Cost Centers	1,519,974	35
36	Provider Participation Fee	717,285	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$16,317,244	40
41	Income before Income Taxes (line 30 minus line 40)**	959,250	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$959,250	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$12,494,623	44
45	Private Pay - Net Inpatient Revenue	264,451	45
46	Medicare - Net Inpatient Revenue	2,096,969	46
47	Other-(specify) Hospice	149,282	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$15,005,325	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.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,716	1,906	\$ 105,706	\$ 55.47	1
2	Assistant Director of Nursing	2,507	2,757	103,114	37.40	2
3	Registered Nurses	31,527	33,582	999,727	29.77	3
4	Licensed Practical Nurses	37,175	39,776	1,011,493	25.43	4
5	CNAs & Orderlies	124,559	136,609	1,465,818	10.73	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	16,130	18,219	299,705	16.45	8
9	Activity Director	1,569	1,810	33,658	18.60	9
10	Activity Assistants	15,084	16,612	170,601	10.27	10
11	Social Service Workers	16,409	18,100	295,400	16.32	11
12	Dietician					12
13	Food Service Supervisor	8,181	8,984	147,970	16.47	13
14	Head Cook					14
15	Cook Helpers/Assistants	28,606	31,445	313,511	9.97	15
16	Dishwashers					16
17	Maintenance Workers	6,309	6,811	129,744	19.05	17
18	Housekeepers	43,637	47,726	472,012	9.89	18
19	Laundry	18,975	20,525	215,310	10.49	19
20	Administrator	2,080	2,080	169,271	81.38	20
21	Assistant Administrator	2,080	2,080	98,167	47.20	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	28,984	31,326	362,752	11.58	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,199	3,429	52,538	15.32	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	6,958	7,239	270,870	37.42	33
34	TOTAL (lines 1 - 33)	395,683	431,016	\$ 6,717,367 *	\$ 15.58	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	321	\$ 14,799	01-03	35
36	Medical Director	Monthly	81,300	09-03	36
37	Medical Records Consultant	32	1,536	10-03	37
38	Nurse Consultant	41	15,808	10-03	38
39	Pharmacist Consultant	Monthly	18,625	10-03	39
40	Physical Therapy Consultant	9	587	10a-03	40
41	Occupational Therapy Consultant	134	10,438	10a-03	41
42	Respiratory Therapy Consultant	12	646	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	8	798	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Renal Therapy Consultant	2,850	108,300	10a-03	47
48					48
49	TOTAL (lines 35 - 48)	3,407	\$ 252,837		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union?

Yes

(2) Are there any dues to nursing home associations included on the cost report?

Yes

If YES, give association name and amount.

IL Council on LTC- \$29,748

(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.

\$41,888

Line10-2

(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?

YESXNO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YESNOX

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.

\$717,285

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?

N/A

(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.

\$63,904

Has any meal income been offset against related costs?

No

Indicate the amount.

\$N/A

(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?

No

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 out of Schedule V?

Yes

(19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

No

Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT