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.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0047035

Facility Name: Mid America Care Center

Address: 4920 North Kenmore Avenue (Number) Chicago (City) 60640 (Zip Code)

County: Cook

Telephone Number: (773) 769-2700 **Fax #** (773) 769-3226

HFS ID Number:

Date of Initial License for Current Owners: 00/00/75

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
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 01/01/10 to 12/31/10 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) Cary N. Drazner, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	310	Skilled (SNF)	310	113,150	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	310	TOTALS	310	113,150	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	56,779	1,448	5,382	63,609	8
9	SNF/PED					9
10	ICF	34,879			34,879	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	91,658	1,448	5,382	98,488	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.04%

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 [X] 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 [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 310 and days of care provided 4,986

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	397,116	111,632	13,034	521,782		521,782		521,782			1
2	Food Purchase		523,591		523,591	(51,903)	471,688	(4,015)	467,673			2
3	Housekeeping	459,424	118,762		578,186		578,186	1,307	579,493			3
4	Laundry	187,582	27,980		215,562		215,562		215,562			4
5	Heat and Other Utilities			323,195	323,195		323,195	4,957	328,152			5
6	Maintenance	154,865	61,346	47,802	264,013		264,013	8,525	272,538			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,198,987	843,311	384,031	2,426,329	(51,903)	2,374,426	10,774	2,385,200			8
	B. Health Care and Programs											
9	Medical Director			84,300	84,300		84,300		84,300			9
10	Nursing and Medical Records	3,407,107	250,690	61,425	3,719,222		3,719,222	(86)	3,719,136			10
10a	Therapy	311,508		9,965	321,473		321,473	(17)	321,456			10a
11	Activities	224,374	14,878	126	239,378		239,378		239,378			11
12	Social Services	223,490			223,490		223,490	(34)	223,456			12
13	CNA Training											13
14	Program Transportation			210	210		210		210			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,166,479	265,568	156,026	4,588,073		4,588,073	(137)	4,587,936			16
	C. General Administration											
17	Administrative	301,149		818,124	1,119,273		1,119,273	(649,140)	470,133			17
18	Directors Fees											18
19	Professional Services			622,364	622,364		622,364	(542,116)	80,248			19
20	Dues, Fees, Subscriptions & Promotions			128,553	128,553		128,553	(92,651)	35,902			20
21	Clerical & General Office Expenses	183,964	71,434	602,584	857,982		857,982	(413,720)	444,262			21
22	Employee Benefits & Payroll Taxes			1,023,287	1,023,287	51,903	1,075,190		1,075,190			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,988	2,988		2,988	697	3,685			24
25	Other Admin. Staff Transportation			4,257	4,257		4,257	(1,316)	2,941			25
26	Insurance-Prop.Liab.Malpractice			285,406	285,406		285,406	13,186	298,592			26
27	Other (specify):*							79,285	79,285			27
28	**TOTAL General Administration**	485,113	71,434	3,487,563	4,044,110	51,903	4,096,013	(1,605,775)	2,490,238			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,850,579	1,180,313	4,027,620	11,058,512		11,058,512	(1,595,138)	9,463,374			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mid America Care Center #0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

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			175,230	175,230		175,230	72,974	248,204			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			115,456	115,456		115,456	7,435	122,891			32
33	Real Estate Taxes							237,027	237,027			33
34	Rent-Facility & Grounds			720,000	720,000		720,000	(720,000)	0			34
35	Rent-Equipment & Vehicles			17,218	17,218		17,218	(17,187)	31			35
36	Other (specify):*											36
37	TOTAL Ownership			1,027,904	1,027,904		1,027,904	(419,751)	608,153			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		342,011	654,458	996,469		996,469		996,469			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			169,725	169,725		169,725		169,725			42
43	Other (specify):*	159,122		42,030	201,152		201,152	(201,152)				43
44	TOTAL Special Cost Centers	159,122	342,011	866,213	1,367,346		1,367,346	(201,152)	1,166,194			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,009,701	1,522,324	5,921,737	13,453,762		13,453,762	(2,216,041)	11,237,721			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

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Reference	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	(4,968)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	27,270	30		9
10	Interest and Other Investment Income	(179,950)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(76)	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	(290)	21		18
19	Entertainment				19
20	Contributions	(61,375)	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	(542,099)	21		24
25	Fund Raising, Advertising and Promotional	(21,347)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(24,000)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(311,830)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,118,666)		$	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)	(1,097,376)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,097,376)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (2,216,041)		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

Mid America Care Center

ID# 0047035

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (3,939)	02	1
2	Prior Period Survey Expense	(500)	21	2
3	Jury Duty- Housekeeping	(17)	03	3
4	Jury Duty- Nursing	(86)	10	4
5	Jury Duty- Social Service	(34)	12	5
6	Jury Duty- Rehab	(17)	10a	6
7	Insurance Refund	(111)	26	7
8	Marketing Salary	(159,122)	43	8
9	Marketing Consultant	(42,030)	43	9
10	Annual Fees	(250)	20	10
11	Bank Charges	(1,120)	21	11
12	Theft & Loss	(2,013)	21	12
13	Non-Allowable Auto Lease	(17,218)	35	13
14	COPE Dues	(11,141)	20	14
15	Non-Allowable Accounting Fee	(5,000)	19	15
16	Building 4930 Real Estate Tax Expense	(7,404)	33	16
17	Non-Allowable Travel	(1,324)	25	17
18	Non-Allowable Legal	(10,182)	19	18
19	Building Company Amortization	(9,152)	31	19
20	Building Company Annual Fees	(400)	20	20
21	Building Company Office Expenses	(2,783)	21	21
22	Building Company Legal & Accounting	(31,341)	19	22
23	Building Company PPA	(10,267)	21	23
24	Building Company Utilities/R&M	(3,106)	06	24
25	Additional R&M	6,727	06	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**	(311,830)		49

Mid America Care Center

ID# 0047035

Report Period Beginning: 01/01/10

Ending: 12/31/10

	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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mid America Care Center # 0047035 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(4,015)											(4,015)	2
3	Housekeeping	(17)		1,300		24							1,307	3
4	Laundry													4
5	Heat and Other Utilities			2,306		2,651							4,957	5
6	Maintenance	(1,347)	3,106	5,640		1,126							8,525	6
7	Other (specify):*													7
8	**TOTAL General Services**	(5,379)	3,106	9,246		3,801							10,774	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(86)											(86)	10
10a	Therapy	(17)											(17)	10a
11	Activities													11
12	Social Services	(34)											(34)	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(137)											(137)	16
	C. General Administration													
17	Administrative			105,069	(755,099)	890							(649,140)	17
18	Directors Fees													18
19	Professional Services	(46,523)	31,341	(527,065)		131							(542,116)	19
20	Fees, Subscriptions & Promotions	(94,513)	400	1,348	39	75							(92,651)	20
21	Clerical & General Office Expenses	(583,072)	13,050	155,644	624	34							(413,720)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			697									697	24
25	Other Admin. Staff Transportation	(1,324)		8									(1,316)	25
26	Insurance-Prop.Liab.Malpractice	(111)	12,429	512		356							13,186	26
27	Other (specify):*			72,080	7,205								79,285	27
28	**TOTAL General Administration**	(725,543)	57,220	(191,707)	(747,231)	1,486							(1,605,775)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(731,059)	60,326	(182,461)	(747,231)	5,287							(1,595,138)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Mid America Care Center** **#** **0047035** **Report Period Beginning:** **01/01/10** **Ending:** **12/31/10**

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	27,270	38,521	6,802		381							72,974	30
31	Amortization of Pre-Op. & Org.	(9,152)	9,152											31
32	Interest	(179,950)	182,690	580		4,115							7,435	32
33	Real Estate Taxes	(7,404)	239,969			4,462							237,027	33
34	Rent-Facility & Grounds		(720,000)	19,498		(19,498)							(720,000)	34
35	Rent-Equipment & Vehicles	(17,218)		31									(17,187)	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(186,454)	(249,668)	26,911		(10,540)							(419,751)	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):*	(201,152)											(201,152)	43
44	**TOTAL Special Cost Centers**	(201,152)											(201,152)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,118,666)	(189,342)	(155,550)	(747,231)	(5,253)							(2,216,041)	45

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Mid America Convalescent Center, Inc.		Building Co.

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	Rent Income	$ 720,000	Mid America Convalescent Center, Inc.	100.00%	$	$ (720,000)	1
2	V	32	Interest	113,466	Mid America Convalescent Center, Inc.	100.00%	296,156	182,690	2
3	V	06	Utilities & Repairs/Maintenance		Mid America Convalescent Center, Inc.	100.00%	3,106	3,106	3
4	V	30	Depreciation		Mid America Convalescent Center, Inc.	100.00%	38,521	38,521	4
5	V	31	Amortization		Mid America Convalescent Center, Inc.	100.00%	9,152	9,152	5
6	V	33	Real Estate Taxes		Mid America Convalescent Center, Inc.	100.00%	239,969	239,969	6
7	V	20	Annual Fees		Mid America Convalescent Center, Inc.	100.00%	400	400	7
8	V	21	Office Expenses		Mid America Convalescent Center, Inc.	100.00%	2,783	2,783	8
9	V	26	Multiperil Insurance		Mid America Convalescent Center, Inc.	100.00%	12,429	12,429	9
10	V	19	Accounting & Legal		Mid America Convalescent Center, Inc.	100.00%	31,341	31,341	10
11	V	21	Adjustment of Prior Period		Mid America Convalescent Center, Inc.	100.00%	10,267	10,267	11
12	V								12
13	V								13
14	Total			$ 833,466			$ 644,124	$ * (189,342)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	3	HOUSEKEEPING	$	MANAGCARE, INC.	100.00%	$ 1,300	$ 1,300	15
16	V	5	UTILITIES		MANAGCARE, INC.	100.00%	2,306	2,306	16
17	V	6	REPAIRS AND MAINT.		MANAGCARE, INC.	100.00%	5,640	5,640	17
18	V	10	NURSING SALARIES		MANAGCARE, INC.	100.00%			18
19	V	17	ADMINISTRATIVE		MANAGCARE, INC.	100.00%	105,069	105,069	19
20	V	19	PROFESSIONAL FEES		MANAGCARE, INC.	100.00%	2,375	2,375	20
21	V	20	FEES, SUBSCRIPTIONS		MANAGCARE, INC.	100.00%	1,348	1,348	21
22	V	21	CLERICAL AND GENERAL		MANAGCARE, INC.	100.00%	155,644	155,644	22
23	V	24	SEMINARS		MANAGCARE, INC.	100.00%	697	697	23
24	V	25	ADMIN. STAFF TRANS.		MANAGCARE, INC.	100.00%	8	8	24
25	V	26	INSURANCE		MANAGCARE, INC.	100.00%	512	512	25
26	V	27	GEN. ADMIN. EMP. BEN.		MANAGCARE, INC.	100.00%	72,080	72,080	26
27	V	30	DEPRECIATION		MANAGCARE, INC.	100.00%	6,802	6,802	27
28	V	32	INTEREST EXPENSE		MANAGCARE, INC.	100.00%	580	580	28
29	V	34	RENT - BUILDING (RELATED)		MANAGCARE, INC.	100.00%	19,498	19,498	29
30	V	35	EQUIPMENT RENTAL		MANAGCARE, INC.	100.00%	31	31	30
31	V	19	HOME OFFICE	529,440	MANAGCARE, INC.	100.00%		(529,440)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 529,440			$ 373,890	$ * (155,550)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$	INTERCARE, LTD. C/O MANAGCARE	100.00%	$ 63,025	$ 63,025	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%	39	39	17
18	V	21	CLERICAL & GENERAL		INTERCARE, LTD. C/O MANAGCARE	100.00%	624	624	18
19	V	27	EMPLOYEE BENEFITS		INTERCARE, LTD. C/O MANAGCARE	100.00%	7,205	7,205	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	818,124	INTERCARE, LTD. C/O MANAGCARE	100.00%		(818,124)	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			$ 818,124			$ 70,893	$ * (747,231)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	3	HOUSEKEEPING	$	MAZEL MANAGEMENT	100.00%	$ 24	$ 24	15
16	V	5	UTILITIES		MAZEL MANAGEMENT		2,651	2,651	16
17	V	6	REPAIRS & MAINT.		MAZEL MANAGEMENT		1,126	1,126	17
18	V	7	EMPLOYEE BEN.-R&M SAL.		MAZEL MANAGEMENT				18
19	V	17	ADMIN.-M. WOLF		MAZEL MANAGEMENT		890	890	19
20	V	19	PROFESSIONAL FEES		MAZEL MANAGEMENT		131	131	20
21	V	20	FEES, SUBSCRIPTIONS		MAZEL MANAGEMENT		75	75	21
22	V	21	CLERICAL & GENERAL		MAZEL MANAGEMENT		34	34	22
23	V	26	INSURANCE		MAZEL MANAGEMENT		356	356	23
24	V	30	DEPRECIATION		MAZEL MANAGEMENT		381	381	24
25	V	31	AMORTIZATION		MAZEL MANAGEMENT				25
26	V	32	INTEREST EXPENSE		MAZEL MANAGEMENT		4,115	4,115	26
27	V	33	REAL ESTATE TAXES				4,462	4,462	27
28	V								28
29	V	34	RENT	19,498				(19,498)	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			$ 19,498			$ 14,245	$ * (5,253)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Mid America Care Center # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	Yosef Davis	Shareholder	Administrative	59.28%	See Attached	9.45	31.50%	Sal/Al. Sal	$ 78,025	17-1,17-7	1
2	Yehoshua Davis	Director	Administrative	0.59%	See Attached	48.00	96.00%	Salary	192,439	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	$ 270,464		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 # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

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: MANAGCARE, INC.
Street Address: 3553 W. PETERSON AVE -3RD FLR
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	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	3	HOUSEKEEPING	PATIENT DAYS	259,131	3	$ 3,420	$	98,488	$ 1,300	1
2	5	UTILITIES	PATIENT DAYS	259,131	3	6,068		98,488	2,306	2
3	6	REPAIRS AND MAINT.	PATIENT DAYS	259,131	3	14,839		98,488	5,640	3
4	10	NURSING SALARIES	PATIENT DAYS	259,131	3			98,488		4
5	17	ADMINISTRATIVE	PATIENT DAYS	259,131	3	276,447	276,447	98,488	105,069	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	259,131	3	6,250		98,488	2,375	6
7	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	259,131	3	3,547		98,488	1,348	7
8	21	CLERICAL AND GENERAL	PATIENT DAYS	259,131	3	409,513	341,493	98,488	155,644	8
9	24	SEMINARS	PATIENT DAYS	259,131	3	1,835		98,488	697	9
10	25	ADMIN. STAFF TRANS.	PATIENT DAYS	259,131	3	22		98,488	8	10
11	26	INSURANCE	PATIENT DAYS	259,131	3	1,347		98,488	512	11
12	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	259,131	3	200,550		98,488	72,080	12
13	30	DEPRECIATION	PATIENT DAYS	259,131	3	17,897		98,488	6,802	13
14	32	INTEREST EXPENSE	PATIENT DAYS	259,131	3	1,526		98,488	580	14
15	34	RENT - BUILDING (RELATED)	PATIENT DAYS	259,131	3	51,300		98,488	19,498	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	259,131	3	81		98,488	31	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 994,642	$ 617,940		$ 373,890	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

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: INTERCARE, LTD. C/O MANAGCARE
Street Address: 3553 W. PETERSON AVE. 3RD FLOOR
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	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	ADMINISTRATIVE	AVG. HOURS WORKED	18	4	$ 120,000	$ 120,000	9	$ 63,025	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	18	4			9		2
3	20	FEES, SUBSCRIPTIONS	AVG. HOURS WORKED	18	4	75		9	39	3
4	21	CLERICAL & GENERAL	AVG. HOURS WORKED	18	4	1,189		9	624	4
5	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	18	4	13,719		9	7,205	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					$ 134,983	$ 120,000		$ 70,893	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

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: MAZEL MANAGEMENT
Street Address: 3553 W.PETERSON AVE.
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	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	3	HOUSEKEEPING	MNGCR. PATIENT DAYS	259,131	3	$ 62	$	98,488	$ 24	1
2	5	UTILITIES	MNGCR. PATIENT DAYS	259,131	3	6,974		98,488	2,651	2
3	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS	259,131	3	2,962		98,488	1,126	3
4	7	EMPLOYEE BEN.-R&M SAL.	MNGCR. PATIENT DAYS	259,131	3			98,488		4
5	17	ADMIN.-M. WOLF	MNGCR. PATIENT DAYS	259,131	3	2,340		98,488	890	5
6	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS	259,131	3	344		98,488	131	6
7	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS	259,131	3	198		98,488	75	7
8	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS	259,131	3	90		98,488	34	8
9	26	INSURANCE	MNGCR. PATIENT DAYS	259,131	3	938		98,488	356	9
10	30	DEPRECIATION	MNGCR. PATIENT DAYS	259,131	3	1,002		98,488	381	10
11	31	AMORTIZATION	MNGCR. PATIENT DAYS	259,131	3			98,488		11
12	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS	259,131	3	10,826		98,488	4,115	12
13	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS	259,131	3	11,741		98,488	4,462	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					$ 37,477	$		$ 14,245	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	MB Financial		X	Mortgage			$	$ 4,738,448			$ 296,156	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	MB Financial		X	Line of Credit				3,250,000			103,561	6
7	Toyota Financial		X	Auto Financing				21,744			11,895	7
8	See Supplemental Schedule										4,695	8
9	TOTAL Facility Related						$	$ 8,010,192			$ 416,307	9
	B. Non-Facility Related*											
10	Interest Income		X								(179,950)	10
11	Interest Income- Bldg. Co.		X								(113,466)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (293,416)	14
15	TOTALS (line 9+line14)						$	$ 8,010,192			$ 122,891	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.)

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 Mid America Care Center # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Allocated From Managcare		X				$	$			$ 580	8
9	Allocated From Mazel		X								4,115	9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										4,695	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.)

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 Mid America Care Center **#** 0047035 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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 2009 report.	$	331,400	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.)	$	279,927	2
3. Under or (over) accrual (line 2 minus line 1).	$	(51,473)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	288,500	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.**	$		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.	$	237,027	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	359,483	8
	2006	315,467	9
	2007	312,099	10
	2008	315,230	11
	2009	275,465	12

2010 Accrual = $275,465 X 1.05 =$288,500 (Rounded)

Allocation From Mazel Management- $4,462

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mid America Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0047035

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-08-410-017-0000	Long Term Care Property	$ 7,403.62	$
2.	14-08-410-018-0000	Long Term Care Property	$ 75,440.04	$ 75,440.04
3.	14-08-410-019-0000	Long Term Care Property	$ 75,440.04	$ 75,440.04
4.	14-08-410-020-0000	Long Term Care Property	$ 75,440.04	$ 75,440.04
5.	14-08-410-021-0000	Long Term Care Property	$ 49,145.40	$ 49,145.40
6.	See Attached	Allocated From Mazel Management	$ 51,712.83	$ 4,506.06
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 334,581.97	$ 279,971.58

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X 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 original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mid America Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0047035

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(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	$	$

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 original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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 Mid America Care Center # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [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	94,500	1979	$ 307,874	1
2					2
3	TOTALS	94,500		$ 307,874	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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					$	$		$	$	$	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	249	249	62,455	17
18	Various			1987	18,422		20	437	437	17,787	18
19	Various			1988	33,825		20	1,353	1,353	30,744	19
20	Various			1989	23,916		20	226	226	23,074	20
21	Various			1990	23,550		20	571	571	23,550	21
22	Various			1991	20,020		20	429	429	11,609	22
23	Various			1992	51,260		20	2,513	2,513	47,042	23
24	Various			1993	7,134		20	357	357	6,490	24
25	Various			1994	32,273		20	1,614	1,614	26,247	25
26	Various			1995	227,831		20	11,236	11,236	177,479	26
27	Various			1996	136,732		20	6,837	6,837	99,622	27
28	Various			1997	26,804		20	1,340	1,340	18,144	28
29	Various			1998	81,506		20	4,075	4,075	50,762	29
30	Various			1999	113,499		20	5,675	5,675	65,404	30
31	Various			2000	308,605		20	15,571	15,571	163,790	31
32	Various			2001	56,517		20	2,826	2,826	26,891	32
33	Various			2002	66,827		20	4,373	4,373	53,181	33
34	Various			2003	33,074		20	2,693	2,693	20,486	34
35	Various			2004	12,735		20	947	947	5,935	35
36	Various			2005	13,227		20	1,213		6,250	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 Mid America Care Center # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	$ 12,518	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)		3,258,613	5,890			(5,890)	3,258,613	67
68	Related Party Allocations (Pages 12H & 12I)		111,380	805		2,606	1,801	94,593	68
69	Financial Statement Depreciation			107,001			(107,001)		69
70	TOTAL (lines 4 thru 69)		$ 4,962,768	$ 113,696		$ 69,824	$ (45,084)	$ 4,510,099	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 # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		$ 4,962,768	$ 113,696		$ 69,824	$ (43,872)	$ 4,510,099	1
2	Cooling Tower	2007	4,099		20	820	820	3,280	2
3	2Nd Fl Cctv System	2007	3,684		20	737	737	2,824	3
4	Fire Damper/ Booster Fan/ Filter	2007	3,091		20	309	309	1,159	4
5	3Rd Fl Cctv System	2007	4,184		20	837	837	3,138	5
6	Cable & Wiring To Build Imp	2007	31,600		20	3,160	3,160	11,587	6
7	4Th Fl 5-Dome Cameras	2007	4,707		20	941	941	3,216	7
8	Hot Water Heater	2007	8,468		20	706	706	2,293	8
9	5Th Fl 4-Ccd Cameras	2007	4,731		20	946	946	3,075	9
10	Dome Security Cameras	2007	4,384		20	626	626	1,931	10
11	Window Treatments	2007	2,687		20	269	269	828	11
12	Cove Base/Wallcovering/Paint	2007	47,210		20	4,721	4,721	14,556	12
13	Cove Base/Wallcovering/Paint	2008	66,639		20	6,664	6,664	13,883	13
14	Gas Regulators For Hot Water Storage Tank	2008	4,121		20	412	412	859	14
15	Replace 20Hp Motor On Hvac System	2008	4,649		20	465	465	969	15
16	Digital Video Recorder For Security System	2008	2,927		20	293	293	610	16
17	Hw Supply Boiler	2008	4,806		20	481	481	1,001	17
18	Miscellaneous Concrete Work	2008	3,750		20	375	375	781	18
19	Building Permit For Construction In Various Areas	2008	9,801		20	980	980	2,042	19
20	Diamond Plate Cooler	2008	2,600		20	130	130	390	20
21	Replace Walls	2008	6,915		20	346	346	1,037	21
22	Diamond Plate Floors In Walk In Freezer	2008	2,600		20	130	130	390	22
23	Cove Base And Surfaces Replacement For Bathroom And 2Nd Flo	2008	2,511		20	126	126	377	23
24	Raypack Boiler	2008	11,475		20	574	574	1,721	24
25	Repaired Expansion Tank	2008	4,470		20	224	224	671	25
26	Walls/Cove Bases/Tiling/Floors/Walls	2009	141,854		20	14,185	14,185	15,368	26
27	Repaired Expansion Tank	2009	4,470		20	447	447	484	27
28	Walls/Covebase/Handrails/Ceiling/Lighting	2009	69,292		20	6,929	6,929	7,507	28
29	Electrical Work	2009	6,300		20	315	315	945	29
30	Remote Annunciator/Conduit/Electrical	2009	5,233		20	262	262	785	30
31	A/C Compressor	2009	18,680		20	934	934	1,868	31
32	Oem Expansion Valve Assem	2009	4,808		20	240	240	481	32
33	Rebuild Front Canopy	2009	4,700		20	235	235	470	33
34	TOTAL (lines 1 thru 33)		$ 5,464,213	$ 113,696		$ 118,641	$ 4,945	$ 4,610,624	34

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 # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		$ 5,464,213	$ 113,696		$ 118,641	$ 4,945	$ 4,610,624	1
2	Front Entry Roof	2009	3,600		20	180	180	360	2
3	Kitchen Door	2009	3,010		20	151	151	301	3
4	New Boiler Tubes	2009	13,500		20	675	675	1,350	4
5	4 Wanderguard Units	2009	6,831		20	342	342	683	5
6	Blinds/Cove/Handrails/Flooring	2009	37,400		20	1,870	1,870	3,740	6
7	Blinds/Cove/Handrails/Flooring	2009	7,444		20	372	372	744	7
8	Drive Way Wall Repair	2009	9,700		20	485	485	970	8
9	Doors	2009	11,390		20	570	570	1,139	9
10	Blinds/Cove/Handrails/Flooring	2009	58,803		20	2,940	2,940	5,880	10
11	2-5000 Watt Recessed Heaters	2009	11,250		20	563	563	1,125	11
12	Wanderguard Signalling Device/Alert System	2009	3,653		20	183	183	365	12
13	Air Conditioning Repair	2009	4,093		20	205	205	409	13
14	Exhaust Manifold	2010	3,162		20	105	105	105	14
15	Sprinkler System Repair	2010	3,653		20	41	41	41	15
16	5Th Floor Corridor: Cove Base And Handrail Installation. Reside	2010	66,261		20	3,313	3,313	3,313	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)		$ 5,707,963	$ 113,696		$ 130,634	$ 16,938	$ 4,631,150	34

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 # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		$ 5,707,963	$ 113,696		$ 130,634	$ 16,938	$ 4,631,150	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
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20									20
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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)		$ 5,707,963	$ 113,696		$ 130,634	$ 16,938	$ 4,631,150	34

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 # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		$ 5,707,963	$ 113,696		$ 130,634	$ 16,938	$ 4,631,150	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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19									19
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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)		$ 5,707,963	$ 113,696		$ 130,634	$ 16,938	$ 4,631,150	34

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 # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 Information								1
2	Buildings:								2
3	310 Beds	1975	3,258,613	5,890			(5,890)	3,258,613	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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25									25
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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.

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 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
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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 (12F & 12G lines 1 thru 33)		$ 3,258,613	$ 5,890		$	$ (5,890)	$ 3,258,613	34

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 # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 Mazel Management	1985	39,211		30	1,307	1,307	33,003	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated From Managcare	2008	5,315	407	20	531	124	1,550	9
10	Allocated From Managcare	1997	4,571		20			4,571	10
11	Allocated From Managcare	1993	359		20	18	18	315	11
12	Allocated From Managcare	1988	560	18	20		(18)	560	12
13	Allocated From Managcare	1986	42,405		20			42,403	13
14									14
15	Allocated From Mazel Management	2007	2,308	59	20	115	56	409	15
16	Allocated From Mazel Management	2006	1,237	32	20	62	30	278	16
17	Allocated From Mazel Management	2005	925	83	20	93	10	507	17
18	Allocated From Mazel Management	2001	823	21	20	41	20	391	18
19	Allocated From Mazel Management	2000	416	11	20	21	10	213	19
20	Allocated From Mazel Management	1998	1,467	47	20	73	26	932	20
21	Allocated From Mazel Management	1997	1,368	35	20	68	33	912	21
22	Allocated From Mazel Management	1996	933	10	20	47	37	679	22
23	Allocated From Mazel Management	1995	211	5	20	11	6	164	23
24	Allocated From Mazel Management	1994	832	15	20	42	27	643	24
25	Allocated From Mazel Management	1993	492	14	20	25	11	429	25
26	Allocated From Mazel Management	1991	369	12	20	18	6	342	26
27	Allocated From Mazel Management	1990	572	12	20	8	(4)	562	27
28	Allocated From Mazel Management	1989	358	8	20	10	2	318	28
29	Allocated From Mazel Management	1987	814	16	20		(16)	814	29
30	Allocated From Mazel Management	1986	3,287		20			3,287	30
31	Allocated From Mazel Management	1985	229		20			229	31
32									32
33	Allocated From Intercare	2001	2,318		20	116	116	1,082	33
34									34

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 # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 111,380	$ 805		$ 2,606	$ 1,801	$ 94,593	34

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 # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	$ 718,682	$ 48,738	$ 58,588	$ 9,850	10	$ 457,405	71
72	Current Year Purchases	190,463	47,490	48,047	557	10	48,037	72
73	Fully Depreciated Assets	928,932				10	928,932	73
74								74
75	TOTALS	$ 1,838,077	$ 96,228	$ 106,635	$ 10,407		$ 1,434,374	75

D. Vehicle Depreciation (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	2007 TOYOTA HIGHLANDER	2007	$	$	$ 1,786	$ 1,786		$	76
77	Facility	2010 Volkswagen Tiguan	2010	22,507	5,151	3,376	(1,775)	5	3,376	77
78		Allocated From Managcare	2010	43,368	5,859	5,772	(87)	5	21,633	78
79										79
80	TOTALS			$ 65,875	$ 11,010	$ 10,934	$ (76)		$ 25,009	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)	$ 7,919,789	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 220,934	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 248,204	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 27,270	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,090,534	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	5th Floor Remodel/Concrete	$ 114,000	92
93			93
94			94
95		$ 114,000	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 Mid America Care Center # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

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: *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 31 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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	$		$ 298,459	$		$ 298,459	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			56,650			56,650	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			299,207			299,207	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				229,783		229,783	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					142	112,228		112,370	13
14	TOTAL			$		$ 654,458	$ 342,011		$ 996,469	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10 (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	$ 437,122	$ 512,565	1
2	Cash-Patient Deposits	6,500	6,813	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,221,842	1,140,066	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	212,123	222,017	6
7	Other Prepaid Expenses	8,085	8,085	7
8	Accounts Receivable (owners or related parties)	1,190,694	1,190,694	8
9	Other(specify): See Attached Schedule	3,258,448	6,254,764	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,334,814	$ 9,335,004	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	887,182	2,364,169	15
16	Equipment, at Historical Cost	583,761	1,843,780	16
17	Accumulated Depreciation (book methods)	(393,426)	(5,770,114)	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	20,027	41,382	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,097,544	$ 2,222,239	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,432,358	$ 11,557,243	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 248,965	$ 277,306	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	69,752	69,752	28
29	Short-Term Notes Payable	3,271,744	3,271,744	29
30	Accrued Salaries Payable	343,414	343,414	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,372	18,372	31
32	Accrued Real Estate Taxes(Sch.IX-B)		288,500	32
33	Accrued Interest Payable	7,901	26,724	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	718,140	834,913	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,678,288	$ 5,130,725	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,738,448	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	34,152	34,152	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 34,152	$ 4,772,600	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,712,440	$ 9,903,325	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,719,918	$ 1,653,918	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,432,358	$ 11,557,243	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Mid America Care Center **#** 0047035 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,410,041	1
2	Restatements (describe):		2
3	**Rounding Adjustment**	(4)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,410,037	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,609,298	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	(2,299,417)	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)**	$ (690,119)	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)**	$ 2,719,918	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 14,505,287	1
2	Discounts and Allowances for all Levels	(1,052,826)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 13,452,461	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,115,298	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,115,298	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	250,811	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	18,084	19
20	Radiology and X-Ray	4,070	20
21	Other Medical Services	37,484	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 310,449	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	179,949	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 179,949	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	4,903	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,903	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,063,060	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,426,329	31
32	Health Care	4,588,073	32
33	General Administration	4,044,110	33
	B. Capital Expense		
34	Ownership	1,027,904	34
	C. Ancillary Expense		
35	Special Cost Centers	1,197,621	35
36	Provider Participation Fee	169,725	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,453,762	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,609,298	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,609,298	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis 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. SEE ACCOUNTANTS' COMPILATION REPORT**

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

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	1,784	2,120	$ 101,027	$ 47.65	1
2	Assistant Director of Nursing	1,824	1,968	83,130	42.24	2
3	Registered Nurses	24,436	25,698	763,783	29.72	3
4	Licensed Practical Nurses	31,825	33,951	888,041	26.16	4
5	CNAs & Orderlies	120,607	132,270	1,507,519	11.40	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	17,073	19,220	311,508	16.21	8
9	Activity Director	1,992	2,200	54,281	24.67	9
10	Activity Assistants	15,458	17,172	170,093	9.91	10
11	Social Service Workers	12,246	13,390	223,490	16.69	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	31,669	34,557	397,116	11.49	15
16	Dishwashers					16
17	Maintenance Workers	8,849	9,824	154,865	15.76	17
18	Housekeepers	41,739	45,673	459,424	10.06	18
19	Laundry	16,086	17,539	187,582	10.70	19
20	Administrator	2,496	2,496	192,439	77.10	20
21	Assistant Administrator	1,968	2,192	93,710	42.75	21
22	Other Administrative	477	477	15,000	31.45	22
23	Office Manager					23
24	Clerical	11,917	13,339	183,964	13.79	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	4,216	4,624	63,607	13.76	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,842	2,842	159,122	55.99	33
34	TOTAL (lines 1 - 33)	349,504	381,552	$ 6,009,701 *	$ 15.75	34

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	300	$ 13,034	01-03	35
36	Medical Director	Monthly	66,300	09-03	36
37	Medical Records Consultant	48	2,208	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	12,059	10-03	39
40	Physical Therapy Consultant	45	2,925	10a-03	40
41	Occupational Therapy Consultant	45	2,925	10a-03	41
42	Respiratory Therapy Consultant	17	1,190	10a-03	42
43	Speech Therapy Consultant	45	2,925	10a-03	43
44	Activity Consultant	2	126	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Renal Therapy Consultant	Monthly	47,158	10-03	47
48	Geriatric Medical Director	Monthly	18,000	09-03	48
49	TOTAL (lines 35 - 48)	502	$ 168,850		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				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.

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Yehoshua Davis	Administrator	0.59%	$ 192,439
Michael Applebaum	Asst. Admin	0.00%	93,710
Yosef Davis	Director	59.28%	15,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 301,149

B. Administrative - Other

Description	Amount
Management Fees- Intercare	$ 818,124
TOTAL (agree to Schedule V, line 17, col. 3)	$ 818,124
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 20,251
See Attached	Legal	45,789
Honkamp Krueger	Unemployment Tax Consult	763
Personnel Planners	Unemployment Tax Consult	1,584
E- Health Data Solutions	Computer Services	6,732
American Data	Computer Services	4,079
Kipp Computer Services	Computer Services	3,900
Kronos	Computer Services	380
Managcare, Inc	Bookkeeping	529,440
Elderlife Development	Architect Consultant	5,830
Cimpar Consulting	Quality Assurance Consult	2,975
See Supplemetal Schedule		641
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 622,364

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 109,947
Unemployment Compensation Insurance	30,595
FICA Taxes	447,854
Employee Health Insurance	310,109
Employee Meals	51,903
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	9,124
Other Employee Benefits	33,657
Holiday Expense	8,248
Pension Expense	66,274
Disability	7,479
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,075,190

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	$ 995
Advertising: Employee Recruitment	275
Health Care Worker Background Check	
(Indicate # of checks performed 29)	327
Patient Background Checks 239	2,713
Licenses & Permits	3,532
Advertising & Promotions	21,347
Dues & Subscriptions	26,598
See Supplemental Schedule	1,462
Less: Public Relations Expense	( )
Non-allowable advertising	(21,347)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 35,902

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,988
Allocated From Managcare	697
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,685

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Assoc of HC $3,720; ILCLTC $26,505**

(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. $ **36,490** Line **10-2**

(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? 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. $ **169,725**
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. $ **51,903** 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 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? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.