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.

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0050336

Facility Name: BELLA VISTA CARE CENTER

Address: 1629 GARDNER LANE (Number) PEORIA HEIGHTS (City) 61614 (Zip Code)

County: PEORIA

Telephone Number: (309) 685-1545 **Fax #** (309) 267-1197

HFS ID Number:

Date of Initial License for Current Owners: 10/1/10

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: DARRYL BUEKER **Telephone Number:** (417) 865-8701
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 1/1/11 to 12/31/11 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) DARRYL BUEKER, CPA, PARTNER
(Firm Name & Address) BKD, LLP, P. O. BOX 1190, SPRINGFIELD, MO 65801-1190
(Telephone) (417) 865-8701 Fax # (417) 865-0682

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

Facility Name & ID Number BELLA VISTA CARE CENTER # 0050336 Report Period Beginning: 1/1/11 Ending: 12/31/11

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 _____

	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	55	Skilled (SNF)	55	20,075	1
2		Skilled Pediatric (SNF/PED)			2
3	55	Intermediate (ICF)	55	20,075	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	110	TOTALS	110	40,150	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	30,016		2,111	32,127	8
9	SNF/PED					9
10	ICF		643		643	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,016	643	2,111	32,770	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.62%

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)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/1/10

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/1/10 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 53 and days of care provided 2,111

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/11 Fiscal Year: 12/31/11

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

Facility Name & ID Number BELLA VISTA CARE CENTER # 0050336 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	256,903	30,962	7,890	295,755		295,755		295,755			1
2	Food Purchase		242,419		242,419		242,419	(4)	242,415			2
3	Housekeeping	119,423	28,639		148,062		148,062		148,062			3
4	Laundry	101,169	15,693		116,862		116,862		116,862			4
5	Heat and Other Utilities			98,572	98,572		98,572	1,809	100,381			5
6	Maintenance	82,020	32	100,746	182,798		182,798	2,660	185,458			6
7	Other (specify):*											7
8	TOTAL General Services	559,515	317,745	207,208	1,084,468		1,084,468	4,465	1,088,933			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	1,344,353	94,047	15,943	1,454,343		1,454,343		1,454,343			10
10a	Therapy	269,635		7,091	276,726		276,726		276,726			10a
11	Activities	89,322	8,909	320	98,551		98,551		98,551			11
12	Social Services	196,412		4,079	200,491		200,491		200,491			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,899,722	102,956	41,833	2,044,511		2,044,511		2,044,511			16
	C. General Administration											
17	Administrative	99,862		104,892	204,754		204,754	(95,664)	109,090			17
18	Directors Fees											18
19	Professional Services			249,663	249,663		249,663	(24,434)	225,229			19
20	Dues, Fees, Subscriptions & Promotions			44,834	44,834		44,834	(21,724)	23,110			20
21	Clerical & General Office Expenses	147,539	21,024	37,173	205,736		205,736	48,796	254,532			21
22	Employee Benefits & Payroll Taxes			386,607	386,607		386,607		386,607			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,608	6,608		6,608	22	6,630			24
25	Other Admin. Staff Transportation			24,715	24,715		24,715	3,013	27,728			25
26	Insurance-Prop.Liab.Malpractice			62,293	62,293		62,293	(671)	61,622			26
27	Other (specify):*							11,191	11,191			27
28	TOTAL General Administration	247,401	21,024	916,785	1,185,210		1,185,210	(79,471)	1,105,739			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,706,638	441,725	1,165,826	4,314,189		4,314,189	(75,006)	4,239,183			29

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

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

Facility Name & ID Number BELLA VISTA CARE CENTER #0050336 Report Period Beginning: 1/1/11 Ending: 12/31/11

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			77,670	77,670		77,670	(49,280)	28,390			30
31	Amortization of Pre-Op. & Org.							137	137			31
32	Interest			35,732	35,732		35,732	(845)	34,887			32
33	Real Estate Taxes			25,302	25,302		25,302	728	26,030			33
34	Rent-Facility & Grounds			288,580	288,580		288,580		288,580			34
35	Rent-Equipment & Vehicles			54,989	54,989		54,989	637	55,626			35
36	Other (specify):*											36
37	**TOTAL Ownership**			482,273	482,273		482,273	(48,623)	433,650			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			120,065	120,065		120,065		120,065			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			60,225	60,225		60,225		60,225			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			180,290	180,290		180,290		180,290			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,706,638	441,725	1,828,389	4,976,752		4,976,752	(123,629)	4,853,123			45

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

Facility Name & ID Number BELLA VISTA CARE CENTER # 0050336 Report Period Beginning: 1/1/11 Ending: 12/31/11

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(51,111)	30		9
10	Interest and Other Investment Income	(1,994)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(4)	2		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	(759)	21		18
19	Entertainment				19
20	Contributions	(1,250)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,519)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(22,145)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax		21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(20)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (78,802)		$	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)	(44,827)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (44,827)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (123,629)		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

BELLA VISTA CARE CENTER

ID# 0050336

Report Period Beginning: 1/1/11

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	IL COUNCIL LTC - COPE	$	20	1
2	MISC INCOME	(20)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				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**	(20)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BELLA VISTA CARE CENTER # 0050336 **Report Period Beginning:** 1/1/11 **Ending:** 12/31/11

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4)	0	0	0	0	0	0	0	0	0	0	(4)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,809	0	0	0	0	0	0	0	0	1,809	5
6	Maintenance	0	0	2,660	0	0	0	0	0	0	0	0	2,660	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4)	0	4,469	0	0	0	0	0	0	0	0	4,465	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(95,664)	0	0	0	0	0	0	0	0	(95,664)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,519)	(25,899)	2,984	0	0	0	0	0	0	0	0	(24,434)	19
20	Fees, Subscriptions & Promotions	(22,145)	0	421	0	0	0	0	0	0	0	0	(21,724)	20
21	Clerical & General Office Expenses	(2,029)	0	50,825	0	0	0	0	0	0	0	0	48,796	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	22	0	0	0	0	0	0	0	0	22	24
25	Other Admin. Staff Transportation	0	0	3,013	0	0	0	0	0	0	0	0	3,013	25
26	Insurance-Prop.Liab.Malpractice	0	0	(671)	0	0	0	0	0	0	0	0	(671)	26
27	Other (specify):*	0	0	11,191	0	0	0	0	0	0	0	0	11,191	27
28	**TOTAL General Administration**	(25,693)	(25,899)	(27,879)	0	0	0	0	0	0	0	0	(79,471)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(25,697)	(25,899)	(23,410)	0	0	0	0	0	0	0	0	(75,006)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BELLA VISTA CARE CENTER # 0050336 **Report Period Beginning:** 1/1/11 **Ending:** 12/31/11

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	(51,111)	0	1,831	0	0	0	0	0	0	0	0	(49,280)	30
31	Amortization of Pre-Op. & Org.	0	0	137	0	0	0	0	0	0	0	0	137	31
32	Interest	(1,994)	0	1,149	0	0	0	0	0	0	0	0	(845)	32
33	Real Estate Taxes	0	0	728	0	0	0	0	0	0	0	0	728	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	637	0	0	0	0	0	0	0	0	637	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(53,105)	0	4,482	0	0	0	0	0	0	0	0	(48,623)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(78,802)	(25,899)	(18,928)	0	0	0	0	0	0	0	0	(123,629)	45

Facility Name & ID Number BELLA VISTA CARE CENTER # 0050336 Report Period Beginning: 1/1/11 Ending: 12/31/11

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		SEE PG6-SUPP				

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V	19	PROFESSIONAL FEES	113,970	PHC CONSULTANTS, LLC		88,071	(25,899)	8
9	V								9
10	V	19	PROFESSIONAL FEES	6,755	MTS CONSULTING		6,755		10
11	V								11
12	V								12
13	V								13
14	Total			$ 120,725			$ 94,826	$ * (25,899)	14

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

Facility Name & ID Number BELLA VISTA CARE CENTER # 0050336 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	HOME OFFICE	$ 104,892	PLATINUM HEALTH CARE, LLC	100.00%	$	$ (104,892)	15
16	V	5	Utilities		PLATINUM HEALTH CARE, LLC		1,809	1,809	16
17	V	6	Repairs & Maintenance		PLATINUM HEALTH CARE, LLC		2,660	2,660	17
18	V	17	Administrative Salary		PLATINUM HEALTH CARE, LLC		9,228	9,228	18
19	V	19	Professional Fees		PLATINUM HEALTH CARE, LLC		2,984	2,984	19
20	V	20	Fees, Subscriptions		PLATINUM HEALTH CARE, LLC		421	421	20
21	V	21	Clerical Salaries		PLATINUM HEALTH CARE, LLC		46,142	46,142	21
22	V	21	Office Expenses		PLATINUM HEALTH CARE, LLC		4,683	4,683	22
23	V	24	Education & Seminars		PLATINUM HEALTH CARE, LLC		22	22	23
24	V	25	Travel		PLATINUM HEALTH CARE, LLC		3,013	3,013	24
25	V	26	Insurance		PLATINUM HEALTH CARE, LLC		(671)	(671)	25
26	V	27	Employee Benefits		PLATINUM HEALTH CARE, LLC		11,191	11,191	26
27	V	30	Depreciation		PLATINUM HEALTH CARE, LLC		1,143	1,143	27
28	V	35	Equipment Rental		PLATINUM HEALTH CARE, LLC		637	637	28
29	V	31	Amortization		PLATINUM HEALTH CARE, LLC		137	137	29
30	V	30	Depreciation		PLATINUM HEALTH CARE, LLC		688	688	30
31	V	32	Interest		PLATINUM HEALTH CARE, LLC		1,149	1,149	31
32	V	33	Real Estate Taxes		PLATINUM HEALTH CARE, LLC		728	728	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 104,892			$ 85,964	$ * (18,928)	39

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

Facility Name & ID Number BELLA VISTA CARE CENTER # 0050336 Report Period Beginning: 1/1/11 Ending: 12/31/11

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	BEN KLEIN	37.5	ALL FAITH PAVILION	CHICAGO	PLATINUM HEALTH	SKOKIE, IL	MANAGEMENT	1
2	BEREKE TRUST	37.5	CAPITOL CARE CENTER	SPRINGFIELD	CARE, LLC			2
3	MARK SHAPIRO	25	COLONIAL HALL CARE CENTER	PRINCETON			BUILDING	3
4			MORTON TERRACE CARE CENTER	MORTON	PHC CONSULTANTS	SKOKIE	CONSULTING	4
5			MORTON VILLA CARE CENTER	MORTON	MTS CONSULTING	SKOKIE	CONSULTING	5
6			RIVER VALLEY SUPPORTING LVG RES	KANKAKEE				6
7			RIVERSHORES CARE CENTER	MARSEILLES				7
8			WOOD GLEN PAVILION	WEST CHICAGO				8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number BELLA VISTA CARE CENTER # 0050336 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	BEN KLEIN		Administrative	37.50	SEE ATTACHED	1	3.45	Mgt Fees	$		1
2	MARK SHAPIRO		Administrative	25.00	SEE ATTACHED	2	5.00	Mgt Fees			2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		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 BELLA VISTA CARE CENTER # 0050336 Report Period Beginning: 1/1/11 Ending: 12/31/11

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: PLATINUM HEALTH CARE, LLC
Street Address: 7444 LONG AVENUE
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847) 329-4100
Fax Number: (847) 329-7652

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Patient Days	876,273	29	$ 48,379	$	32,770	$ 1,809	1
2	6	Repairs & Maintenance	Patient Days	876,273	29	71,131		32,770	2,660	2
3	17	Administrative Salary	Patient Days	876,273	29	246,751	246,751	32,770	9,228	3
4	19	Professional Fees	Patient Days	876,273	29	79,792		32,770	2,984	4
5	20	Fees, Subscriptions	Patient Days	876,273	29	11,255		32,770	421	5
6	21	Clerical Salaries	Patient Days	876,273	29	1,233,841	1,233,841	32,770	46,142	6
7	21	Office Expenses	Patient Days	876,273	29	125,226		32,770	4,683	7
8	24	Education & Seminars	Patient Days	876,273	29	577		32,770	22	8
9	25	Travel	Patient Days	876,273	29	80,576		32,770	3,013	9
10	26	Insurance	Patient Days	876,273	29	(17,938)		32,770	(671)	10
11	27	Employee Benefits	Patient Days	876,273	29	299,243		32,770	11,191	11
12	30	Depreciation	Patient Days	876,273	29	30,566		32,770	1,143	12
13	35	Equipment Rental	Patient Days	876,273	29	17,025		32,770	637	13
14	31	Amortization	Patient Days	876,273	29	3,657		32,770	137	14
15	30	Depreciation	Patient Days	876,273	29	18,405		32,770	688	15
16	32	Interest	Patient Days	876,273	29	30,718		32,770	1,149	16
17	33	Real Estate Taxes	Patient Days	876,273	29	19,475		32,770	728	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,298,679	$ 1,480,592		$ 85,964	25

Facility Name & ID Number BELLA VISTA CARE CENTER # 0050336 Report Period Beginning: 1/1/11 Ending: 12/31/11

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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	FIRST MERIT		X	LINE OF CREDIT							10,336	6
7	HFG		X	LINE OF CREDIT							25,396	7
8												8
9	TOTAL Facility Related						$	$			$ 35,732	9
	B. Non-Facility Related*											
10	INTEREST INCOME OFFSET										(1,994)	10
11												11
12												12
13	ALLOCATION FROM PLATINUM										1,149	13
14	TOTAL Non-Facility Related						$	$			$ (845)	14
15	TOTALS (line 9+line14)						$	$			$ 34,887	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #** 32

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

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

Facility Name & ID Number BELLA VISTA CARE CENTER **#** 0050336 **Report Period Beginning:** 1/1/11 **Ending:** 12/31/11

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 29,745	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.)		$ 51,362	2
3. Under or (over) accrual (line 2 minus line 1).		$ 21,617	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$	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.		$ 21,617	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2006	50,735	8
2007	49,583	9
2008	52,012	10
2009		11
2010	51,362	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BELLA VISTA CARE CENTER COUNTY PEORIA

FACILITY IDPH LICENSE NUMBER 0050336

CONTACT PERSON REGARDING THIS REPORT DARRYL BUEKER

TELEPHONE (417) 865-8701 FAX #: (417) 865-0682

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

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-15-426-004	Nursing Home	$ 51,362.04	$ 51,362.04
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 51,362.04	$ 51,362.04

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

Facility Name & ID Number BELLA VISTA CARE CENTER # 0050336 Report Period Beginning: 1/1/11 Ending: 12/31/11

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,000 B. General Construction Type: Exterior CEMENT BLOCK Frame METAL BEAM Number of Stories 1 NO BASEMENT

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

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

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (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).

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

1. Total Amount Incurred: 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	Nursing Home	400,860		$	1
2					2
3	TOTALS	400,860		$	3

Facility Name & ID Number BELLA VISTA CARE CENTER # 0050336 Report Period Beginning: 1/1/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WALL COVERING REPLACEMENT			2008	4,095		5	819	819	3,071	9
10	REPLACEMENT OF LEGS ON TABLES			2008	4,234		10	423	423	1,517	10
11	WATER HEATER			2008	1,500		10	150	150	538	11
12	OUTLET INSTALLATION			2008	585		10	59	59	205	12
13	REPAIR GAPS OVER BUILDING			2008	3,600		40	92	92	315	13
14	SMOKE DETECTORS			2008	6,763		10	676	676	2,311	14
15	50 GALLON ELECTYRIC AOSMITH HEATER			2008	751		10	75	75	232	15
16	TEN REPAIR KITS OUTSIDE FAUCETS			2008	1,250		10	125	125	385	16
17	PANACEA PULSE AIR & PUMP			2008	3,364		10	337	337	1,037	17
18	NEW YORK ROOFTOP UNIT			2008	7,800		10	780	780	2,405	18
19	REDO TWO FACES & PAINT THE CABINET			2008	1,860		10	186	186	574	19
20	LARGE AMT OF GREASE PUMPED			2008	875		10	88	88	270	20
21	STRUCTURAL IMPROVEMENTS-CONTRACT-AM REDMODELING			2009	5,000		15	333	333	972	21
22	HVAC UNIT			2009	18,375		10	1,838	1,838	5,359	22
23	REMODEL DON (RIVERSIDE)-CONTRACT-AM REMODELING			2009	9,500		15	633	633	1,847	23
24	KEYS AND LOCKS			2009	837		10	84	84	244	24
25	FIRE ALARM-REPLACE CONTROL PANEL			2009	2,023		10	202	202	539	25
26	DOORS AND INSTALLATION			2009	7,435		15	496	496	1,280	26
27	LIGHTING-PERIMETER			2009	3,500		15	233	233	583	27
28	GENERATOR WORK			2009	1,363		12	114	114	294	28
29	VIDEO RECORDER FOR SECURITY			2009	1,295		5	259	259	626	29
30	TEMPORARY POWER FROM GENERATOR			2009	970		12	81	81	202	30
31	GENERATOR PANEL			2009	1,873		12	156	156	390	31
32	ASBESTOS INSPECTION			2009	2,806		10	281	281	655	32
33	KITCHEN PLUMBING REPLACEMENT			2009	9,500		25	380	380	792	33
34	COUNTER TOP FOR NURSES STATION			2009	1,985		15	132	132	309	34
35	REFLECTIVE FILM MIRROR			2009	3,103		10	310	310	698	35
36	ASBESTOS INSPECTION			2009	2,794		10	279	279	629	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 BELLA VISTA CARE CENTER # 0050336 Report Period Beginning: 1/1/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	STAINLESS STEEL KITCHEN MODIFICATIONS	2010	$ 3,525	$	15	$ 235	$ 235	$ 274	37
38	CEILING ACCESS DOOR	2011	3,454		15	211	211	211	38
39	WATER HEATER	2011	6,104		10	560	560	560	39
40	DOORS-NORTH HALLWAY	2011	3,565		20	134	134	134	40
41	CUBICLE CURTAINS, ETC	2011	4,057		5	135	135	135	41
42	HOLDING TANK	2011	3,994		10	33	33	33	42
43				24,078			(24,078)		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	Allocation from Platinum			517		517			66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 133,735	$ 24,595		$ 11,446	$ (13,149)	$ 29,626	70

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

Facility Name & ID Number BELLA VISTA CARE CENTER # 0050336 Report Period Beginning: 1/1/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 130,564	$ 1,827	$ 12,923	$ 11,096		$ 30,954	71
72	Current Year Purchases	51,765	51,765	2,707	(49,058)		2,707	72
73	Fully Depreciated Assets							73
74	Allocation from Platinum		1,314	1,314				74
75	TOTALS	$ 182,329	$ 54,906	$ 16,944	$ (37,962)		$ 33,661	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 316,064	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 79,501	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 28,390	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (51,111)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 63,287	85	

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

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

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number BELLA VISTA CARE CENTER # 0050336 Report Period Beginning: 1/1/11 Ending: 12/31/11

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
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.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 46,829 Description: Md eqp 20,547; Ldy 7,536; Ice mach 3,452; Dish mach 1,201; Copier 10,578; Water tmt 1,005 Misc 2,510
    (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		Ford 2009	$ 679.99	$ 8,160	17
18					18
19					19
20					20
21	TOTAL		$ 679.99	$ 8,160	21

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

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

Facility Name & ID Number BELLA VISTA CARE CENTER # 0050336 Report Period Beginning: 1/1/11 Ending: 12/31/11

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

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

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number BELLA VISTA CARE CENTER # 0050336 Report Period Beginning: 1/1/11 Ending: 12/31/11

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-03	hrs	$	280	$ 6,372	$	280	$ 6,372	1
2	Licensed Speech and Language Development Therapist	10a-03	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-03	hrs							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				110,436		110,436	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Resp Therapist					719			719	12
13	Other (specify): Lab & X-ray	39-02					9,629		9,629	13
14	TOTAL			$	280	$ 7,091	$ 120,065	280	$ 127,156	14

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

STATE OF ILLINOIS

Facility Name & ID Number BELLA VISTA CARE CENTER # 0050336 Report Period Beginning: 1/1/11 Ending: 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/11 (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	$ (28,996)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,024,518		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	34,692		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,030,214	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	133,734		15
16	Equipment, at Historical Cost	182,329		16
17	Accumulated Depreciation (book methods)	(273,733)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 42,330	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,072,544	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 292,050	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,750,145		29
30	Accrued Salaries Payable	111,178		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	31,866		36
37	Due Others, Adv Billing	99,623		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,284,862	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,284,862	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (212,318)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,072,544	$	48

***(See instructions.)**

Facility Name & ID Number BELLA VISTA CARE CENTER # 0050336 **Report Period Beginning:** 1/1/11 **Ending:** 12/31/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 77,227	1
2	Restatements (describe):		2
3	**Rounding**	1	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 77,228	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(189,546)	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	(100,000)	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)**	$ (289,546)	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)**	$ (212,318)	24 *

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

Facility Name & ID Number BELLA VISTA CARE CENTER # 0050336 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	$ 4,559,638	1
2	Discounts and Allowances for all Levels	(287,362)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,272,276	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	399,972	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 399,972	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	107,499	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,713	19
20	Radiology and X-Ray	732	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 112,944	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,994	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,994	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC INCOME	20	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 20	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,787,206	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,084,468	31
32	Health Care	2,044,511	32
33	General Administration	1,185,210	33
	B. Capital Expense		
34	Ownership	482,273	34
	C. Ancillary Expense		
35	Special Cost Centers	120,065	35
36	Provider Participation Fee	60,225	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,976,752	40
41	**Income before Income Taxes (line 30 minus line 40)****	(189,546)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (189,546)	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

TAX RETURN FILED ON CASH BASIS

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

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

Facility Name & ID Number BELLA VISTA CARE CENTER # 0050336 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	3,993	4,273	$ 131,917	$ 30.87	1
2	Assistant Director of Nursing	303	319	9,674	30.33	2
3	Registered Nurses	8,933	9,640	264,879	27.48	3
4	Licensed Practical Nurses	18,743	19,962	476,231	23.86	4
5	CNAs & Orderlies	42,831	44,777	451,165	10.08	5
6	CNA Trainees					6
7	Licensed Therapist	391	391	24,785	63.39	7
8	Rehab/Therapy Aides	12,347	14,042	244,850	17.44	8
9	Activity Director	1,824	1,952	28,691	14.70	9
10	Activity Assistants	6,028	6,330	60,631	9.58	10
11	Social Service Workers	10,428	11,671	196,412	16.83	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,338	47,764	20.43	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,797	21,883	209,139	9.56	15
16	Dishwashers					16
17	Maintenance Workers	5,830	6,192	82,020	13.25	17
18	Housekeepers	8,910	10,107	119,423	11.82	18
19	Laundry	9,610	10,107	101,169	10.01	19
20	Administrator	1,984	2,280	99,862	43.80	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,770	8,330	147,539	17.71	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	998	1,039	10,487	10.09	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	163,720	175,633	$ 2,706,638 *	$ 15.41	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	188	$ 7,890	1-03	35
36	Medical Director	Monthly	14,400	9-03	36
37	Medical Records Consultant	Quarterly	3,204	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,539	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	65	4,079	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	253	$ 35,112		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

Facility Name & ID Number BELLA VISTA CARE CENTER # 0050336 Report Period Beginning: 1/1/11 Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
LORENE FOUST	ADMINISTRATOR		$ 96,862
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 96,862

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
SEE ATTACHED SCHEDULE		$ 249,663
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 249,663

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 69,538
Unemployment Compensation Insurance	62,531
FICA Taxes	206,676
Employee Health Insurance	39,574
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K	1,000
EMPLOYEE BENEFITS - OTHER	7,208
EMPLOYEE PHYSICAL EXAM	80
TOTAL (agree to Schedule V, line 22, col.8)	$ 386,607

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	$
Advertising: Employee Recruitment	5,337
Health Care Worker Background Check	4,288
(Indicate # of checks performed 9)	
Patient Background Checks 116	
ADVERTISING & MARKETING	19,145
DUES & SUBSCRIPTIONS	10,211
LICENSES	2,853
ALLOCATION FROM PLATINUM	421
Less: Public Relations Expense	( )
Non-allowable advertising	(19,145)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,110

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	6,608
ALLOCATION FROM PLATINUM	22
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,630

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BELLA VISTA CARE CENTER # 0050336 Report Period Beginning: 1/1/11 Ending: 12/31/11

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

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

Facility Name & ID Number BELLA VISTA CARE CENTER **#** 0050336 **Report Period Beginning:** 1/1/11 **Ending:** 12/31/11

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LTC $10,065**

(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 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **191** 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.

(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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **60,225**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(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? 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?
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name:

(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.