FOR BHF USE

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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.

I. IDPH License ID Number: 0050336

Facility Name: BELLA VISTA CARE CTR

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: PAMELA PHILLIPS **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 1/1/12 to 12/31/12 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 CTR # 0050336 Report Period Beginning: 1/1/12 Ending: 12/31/12

III. STATISTICAL DATA

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

	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	20,130	1
2		Skilled Pediatric (SNF/PED)			2
3	55	Intermediate (ICF)	55	20,130	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	110	TOTALS	110	40,260	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	34,028		1,488	35,516	8
9	SNF/PED					9
10	ICF		1,017		1,017	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,028	1,017	1,488	36,533	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.74%

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 [ ] 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 1,403

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: 12/31/12 Fiscal Year: 12/31/12

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

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

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	255,675	39,394	7,869	302,938		302,938		302,938			1
2	Food Purchase		229,726		229,726		229,726	(4)	229,722			2
3	Housekeeping	121,714	26,918		148,632		148,632		148,632			3
4	Laundry	94,345	18,305		112,650		112,650		112,650			4
5	Heat and Other Utilities			106,137	106,137		106,137	1,772	107,909			5
6	Maintenance	70,374		76,009	146,383		146,383	2,669	149,052			6
7	Other (specify):*											7
8	TOTAL General Services	542,108	314,343	190,015	1,046,466		1,046,466	4,437	1,050,903			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	1,499,961	85,088	16,539	1,601,588		1,601,588		1,601,588			10
10a	Therapy	220,310	1,078	37,937	259,325		259,325		259,325			10a
11	Activities	64,384	34,448	5,368	104,200		104,200		104,200			11
12	Social Services	197,313	4,928		202,241		202,241		202,241			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,981,968	125,542	74,244	2,181,754		2,181,754		2,181,754			16
	C. General Administration											
17	Administrative	117,653		122,892	240,545		240,545	11,285	251,830			17
18	Directors Fees											18
19	Professional Services			251,778	251,778		251,778	(1,861)	249,917			19
20	Dues, Fees, Subscriptions & Promotions			35,903	35,903		35,903	(9,817)	26,086			20
21	Clerical & General Office Expenses	203,820	28,186	44,057	276,063		276,063	50,974	327,037			21
22	Employee Benefits & Payroll Taxes			463,305	463,305		463,305	(5,239)	458,066			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,259	4,259		4,259	315	4,574			24
25	Other Admin. Staff Transportation			23,080	23,080		23,080	2,370	25,450			25
26	Insurance-Prop.Liab.Malpractice			80,123	80,123		80,123	459	80,582			26
27	Other (specify):*							12,544	12,544			27
28	TOTAL General Administration	321,473	28,186	1,025,397	1,375,056		1,375,056	61,030	1,436,086			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,845,549	468,071	1,289,656	4,603,276		4,603,276	65,467	4,668,743			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 CTR #0050336 Report Period Beginning: 1/1/12 Ending: 12/31/12

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			4,716	4,716		4,716	30,263	34,979			30
31	Amortization of Pre-Op. & Org.							84	84			31
32	Interest			113,848	113,848		113,848	1,197	115,045			32
33	Real Estate Taxes			92,458	92,458		92,458	(39,408)	53,050			33
34	Rent-Facility & Grounds			288,580	288,580		288,580	217	288,797			34
35	Rent-Equipment & Vehicles			60,534	60,534		60,534	745	61,279			35
36	Other (specify):*											36
37	TOTAL Ownership			560,136	560,136		560,136	(6,902)	553,234			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			65,302	65,302		65,302		65,302			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			413,118	413,118		413,118		413,118			42
43	Other (specify):*							(4,552)	(4,552)			43
44	TOTAL Special Cost Centers			478,420	478,420		478,420	(4,552)	473,868			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,845,549	468,071	2,328,212	5,641,832		5,641,832	54,013	5,695,845			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 CTR # 0050336 Report Period Beginning: 1/1/12 Ending: 12/31/12

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				9
10	Interest and Other Investment Income	(4)	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				18
19	Entertainment				19
20	Contributions	(1,000)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,375)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(10,250)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(16,882)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (32,515)		$	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)	86,528		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 86,528		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 54,013		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 CTR

ID# 0050336

Report Period Beginning: 1/1/12

Ending: 12/31/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2	MISC INCOME	(136)	21	2
3	ADJ TO S/L DEPR	27,914	30	3
4	REAL ESTATE TAXES	(40,108)	33	4
5	MARKETING SALARIES	(3,915)	43	5
6	MARKETING EMPLOYEE BENEFITS	(637)	43	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
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26				26
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30				30
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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**	(16,882)		49

STATE OF ILLINOIS

Summary A

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

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	1,772	0	0	0	0	0	0	0	0	1,772	5
6	Maintenance	0	0	2,669	0	0	0	0	0	0	0	0	2,669	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4)	0	4,441	0	0	0	0	0	0	0	0	4,437	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	11,285	0	0	0	0	0	0	0	0	11,285	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(4,375)	(3,253)	5,767	0	0	0	0	0	0	0	0	(1,861)	19
20	Fees, Subscriptions & Promotions	(10,250)	0	433	0	0	0	0	0	0	0	0	(9,817)	20
21	Clerical & General Office Expenses	(1,136)	0	52,110	0	0	0	0	0	0	0	0	50,974	21
22	Employee Benefits & Payroll Taxes	0	(5,239)	0	0	0	0	0	0	0	0	0	(5,239)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	315	0	0	0	0	0	0	0	0	315	24
25	Other Admin. Staff Transportation	0	0	2,370	0	0	0	0	0	0	0	0	2,370	25
26	Insurance-Prop.Liab.Malpractice	0	0	459	0	0	0	0	0	0	0	0	459	26
27	Other (specify):*	0	0	12,544	0	0	0	0	0	0	0	0	12,544	27
28	**TOTAL General Administration**	(15,761)	(8,492)	85,283	0	0	0	0	0	0	0	0	61,030	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(15,765)	(8,492)	89,724	0	0	0	0	0	0	0	0	65,467	29

STATE OF ILLINOIS

Summary B

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

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	27,914	0	2,349	0	0	0	0	0	0	0	0	30,263	30
31	Amortization of Pre-Op. & Org.	0	0	84	0	0	0	0	0	0	0	0	84	31
32	Interest	(4)	0	1,201	0	0	0	0	0	0	0	0	1,197	32
33	Real Estate Taxes	(40,108)	0	700	0	0	0	0	0	0	0	0	(39,408)	33
34	Rent-Facility & Grounds	0	0	217	0	0	0	0	0	0	0	0	217	34
35	Rent-Equipment & Vehicles	0	0	745	0	0	0	0	0	0	0	0	745	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(12,198)	0	5,296	0	0	0	0	0	0	0	0	(6,902)	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):*	(4,552)	0	0	0	0	0	0	0	0	0	0	(4,552)	43
44	**TOTAL Special Cost Centers**	(4,552)	0	0	0	0	0	0	0	0	0	0	(4,552)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(32,515)	(8,492)	95,020	0	0	0	0	0	0	0	0	54,013	45

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

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	133,100	PHC CONSULTANTS, LLC		129,847	(3,253)	8
9	V		22	EMPLOYEE BENEFITS	5,239	PHC CONSULTANTS, LLC			(5,239)	9
10	V									10
11	V		19	PROFESSIONAL FEES	842	MTS CONSULTING		842		11
12	V									12
13	V									13
14	Total				$ 139,181			$ 130,689	$ * (8,492)	14

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

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

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	$	PLATINUM HEALTH CARE, LLC	100.00%	$	$	15
16	V	5	Utilities		PLATINUM HEALTH CARE, LLC		1,772	1,772	16
17	V	6	Repairs & Maintenance		PLATINUM HEALTH CARE, LLC		2,669	2,669	17
18	V	17	Administrative Salary		PLATINUM HEALTH CARE, LLC		11,285	11,285	18
19	V	19	Professional Fees		PLATINUM HEALTH CARE, LLC		5,767	5,767	19
20	V	20	Fees, Subscriptions		PLATINUM HEALTH CARE, LLC		433	433	20
21	V	21	Clerical Salaries		PLATINUM HEALTH CARE, LLC		47,698	47,698	21
22	V	21	Office Expenses		PLATINUM HEALTH CARE, LLC		4,412	4,412	22
23	V	24	Education & Seminars		PLATINUM HEALTH CARE, LLC		315	315	23
24	V	25	Travel		PLATINUM HEALTH CARE, LLC		2,370	2,370	24
25	V	26	Insurance		PLATINUM HEALTH CARE, LLC		459	459	25
26	V	27	Employee Benefits		PLATINUM HEALTH CARE, LLC		12,544	12,544	26
27	V	30	Depreciation		PLATINUM HEALTH CARE, LLC		1,621	1,621	27
28	V	35	Equipment Rental		PLATINUM HEALTH CARE, LLC		745	745	28
29	V	31	Amortization		PLATINUM HEALTH CARE, LLC		84	84	29
30	V	30	Depreciation		PLATINUM HEALTH CARE, LLC		728	728	30
31	V	32	Interest		PLATINUM HEALTH CARE, LLC		1,201	1,201	31
32	V	33	Real Estate Taxes		PLATINUM HEALTH CARE, LLC		700	700	32
33	V	34	Office Rent		PLATINUM HEALTH CARE, LLC		217	217	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 95,020	$ * 95,020	39

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

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

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				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	KANKAKEE				7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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

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	2	3.85	Mgt Fees	$		1
2	MARK SHAPIRO		Administrative	25.00	SEE ATTACHED	4	10.00	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 CTR # 0050336 Report Period Beginning: 1/1/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	923,219	30	$ 44,791	$	36,533	$ 1,772	1
2	6	Repairs & Maintenance	Patient Days	923,219	30	67,446		36,533	2,669	2
3	17	Administrative Salary	Patient Days	923,219	30	285,177	285,177	36,533	11,285	3
4	19	Professional Fees	Patient Days	923,219	30	145,744		36,533	5,767	4
5	20	Fees, Subscriptions	Patient Days	923,219	30	10,954		36,533	433	5
6	21	Clerical Salaries	Patient Days	923,219	30	1,205,375	1,205,375	36,533	47,698	6
7	21	Office Expenses	Patient Days	923,219	30	111,487		36,533	4,412	7
8	24	Education & Seminars	Patient Days	923,219	30	7,956		36,533	315	8
9	25	Travel	Patient Days	923,219	30	59,896		36,533	2,370	9
10	26	Insurance	Patient Days	923,219	30	11,602		36,533	459	10
11	27	Employee Benefits	Patient Days	923,219	30	316,988		36,533	12,544	11
12	30	Depreciation	Patient Days	923,219	30	40,988		36,533	1,621	12
13	35	Equipment Rental	Patient Days	923,219	30	18,824		36,533	745	13
14	31	Amortization	Patient Days	923,219	30	2,134		36,533	84	14
15	30	Depreciation	Patient Days	923,219	30	18,405		36,533	728	15
16	32	Interest	Patient Days	923,219	30	30,356		36,533	1,201	16
17	33	Real Estate Taxes	Patient Days	923,219	30	17,678		36,533	700	17
18	34	Office Rent	Patient Days	923,219	30	5,488		36,533	217	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,401,289	$ 1,490,552		$ 95,020	25

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	HFG		X	LINE OF CREDIT							113,848	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 113,848	9
	B. Non-Facility Related*											
10	INTEREST INCOME OFFSET										(4)	10
11												11
12												12
13	ALLOCATION FROM PLATINUM										1,201	13
14	TOTAL Non-Facility Related						$	$			$ 1,197	14
15	TOTALS (line 9+line14)						$	$			$ 115,045	15

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

*** 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 CTR # 0050336 Report Period Beginning: 1/1/12 Ending: 12/31/12

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	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.)		$ 52,350	2
3. Under or (over) accrual (line 2 minus line 1).		$ 52,350	3
4. Real Estate Tax accrual used for 2012 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.		$ 52,350	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	49,583	8
	2008	52,012	9
	2009		10
	2010	51,362	11
	2011	52,350	12

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

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BELLA VISTA CARE CTR COUNTY PEORIA

FACILITY IDPH LICENSE NUMBER 0050336

CONTACT PERSON REGARDING THIS REPORT PAMELA PHILLIPS

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 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-15-426-004	Nursing Home	$ 52,350.28	$ 52,350.28
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 52,350.28	$ 52,350.28

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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 CTR # 0050336 Report Period Beginning: 1/1/12 Ending: 12/31/12

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 CTR # 0050336 Report Period Beginning: 1/1/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

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

	1 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	3,890	9
10	REPLACEMENT OF LEGS ON TABLES			2008	4,234		10	424	424	1,940	10
11	WATER HEATER			2008	1,500		10	150	150	688	11
12	OUTLET INSTALLATION			2008	585		10	59	59	264	12
13	REPAIR GAPS OVER BUILDING			2008	3,600		40	92	92	407	13
14	SMOKE DETECTORS			2008	6,763		10	676	676	2,987	14
15	50 GALLON ELECTYRIC AOSMITH HEATER			2008	751		10	75	75	307	15
16	TEN REPAIR KITS OUTSIDE FAUCETS			2008	1,250		10	125	125	510	16
17	PANACEA PULSE AIR & PUMP			2008	3,364		10	336	336	1,373	17
18	NEW YORK ROOFTOP UNIT			2008	7,800		10	780	780	3,185	18
19	REDO TWO FACES & PAINT THE CABINET			2008	1,860		10	186	186	760	19
20	LARGE AMT OF GREASE PUMPED			2008	875		10	88	88	358	20
21	STRUCTURAL IMPROVEMENTS-CONTRACT-AM REDMODELING			2009	5,000		15	333	333	1,305	21
22	HVAC UNIT			2009	18,375		10	1,838	1,838	7,197	22
23	REMODEL DON (RIVERSIDE)-CONTRACT-AM REMODELING			2009	9,500		15	633	633	2,480	23
24	KEYS AND LOCKS			2009	837		10	84	84	328	24
25	FIRE ALARM-REPLACE CONTROL PANEL			2009	2,023		10	202	202	741	25
26	DOORS AND INSTALLATION			2009	7,435		15	496	496	1,776	26
27	LIGHTING-PERIMETER			2009	3,500		15	233	233	816	27
28	GENERATOR WORK			2009	1,363		12	114	114	408	28
29	VIDEO RECORDER FOR SECURITY			2009	1,295		5	259	259	885	29
30	TEMPORARY POWER FROM GENERATOR			2009	970		12	81	81	283	30
31	GENERATOR PANEL			2009	1,873		12	156	156	546	31
32	ASBESTOS INSPECTION			2009	2,806		10	281	281	936	32
33	KITCHEN PLUMBING REPLACEMENT			2009	9,500		25	380	380	1,172	33
34	COUNTER TOP FOR NURSES STATION			2009	1,985		15	132	132	441	34
35	REFLECTIVE FILM MIRROR			2009	3,103		10	310	310	1,008	35
36	ASBESTOS INSPECTION			2009	2,794		10	279	279	908	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 CTR # 0050336 Report Period Beginning: 1/1/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

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

	1 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	$ 509	37
38	CEILING ACCESS DOOR	2011	3,454		15	230	230	441	38
39	WATER HEATER	2011	6,104		10	611	611	1,171	39
40	DOORS-NORTH HALLWAY	2011	3,565		20	178	178	312	40
41	CUBICLE CURTAINS, ETC	2011	4,057		5	811	811	946	41
42	HOLDING TANK	2011	3,994		10	399	399	432	42
43	CIRCUITS	2012	2,750		15	153	153	153	43
44	SPRINKLER WORK	2012	8,890		15	140	140	140	44
45	ELECTRICAL WORK-OFFICE	2012	5,003		15	231	231	231	45
46	PLUMBING	2012	2,722		15	45	45	45	46
47				2,890			(2,890)		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			519		519			66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 153,100	$ 3,409		$ 13,173	$ 9,764	$ 42,279	70

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

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

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	$ 182,329	$ 1,826	$ 18,099	$ 16,273		$ 51,760	71
72	Current Year Purchases	50,718		1,877	1,877		1,877	72
73	Fully Depreciated Assets							73
74	ALLOCATION FROM PLATINUM		1,830	1,830				74
75	TOTALS	$ 233,047	$ 3,656	$ 21,806	$ 18,150		$ 53,637	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)	$ 386,147	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 7,065	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 34,979	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 27,914	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 95,916	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 CTR # 0050336 Report Period Beginning: 1/1/12 Ending: 12/31/12

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

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: $ 52,374 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		Ford E-350 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 CTR # 0050336 Report Period Beginning: 1/1/12 Ending: 12/31/12

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 CTR # 0050336 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	$	307	$ 17,292	$	307	$ 17,292	1
2	Licensed Speech and Language Development Therapist	10a-03	hrs		99	6,654		99	6,654	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-03	hrs		198	13,536		198	13,536	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				59,361		59,361	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Resp Therapist	10a-03				455			455	12
13	Other (specify): Lab & X-ray	39-02					5,941		5,941	13
14	TOTAL			$	604	$ 37,937	$ 65,302	604	$ 103,239	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 CTR # 0050336 Report Period Beginning: 1/1/12 Ending: 12/31/12

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/12 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,610,539	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,248,989		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	32,152		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)**	$ 4,891,680	$	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	153,098		15
16	Equipment, at Historical Cost	233,048		16
17	Accumulated Depreciation (book methods)	(386,146)		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)**	$	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,891,680	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 376,536	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	3,722,423		29
30	Accrued Salaries Payable	77,916		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	90,052		36
37	Due Others	(72,149)		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,194,778	$	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)**	$ 4,194,778	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 696,902	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,891,680	$	48

*(See instructions.)

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

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (212,318)	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)**	$ (212,319)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	909,221	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 909,221	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)**	$ 696,902	24	*

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

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

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,501,370	1
2	Discounts and Allowances for all Levels	620,580	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,121,950	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	347,809	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 347,809	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	78,177	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,217	19
20	Radiology and X-Ray	760	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 81,154	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC INCOME	136	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 136	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,551,053	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,046,466	31
32	Health Care	2,181,754	32
33	General Administration	1,375,056	33
	B. Capital Expense		
34	Ownership	560,136	34
	C. Ancillary Expense		
35	Special Cost Centers	65,302	35
36	Provider Participation Fee	413,118	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,641,832	40
41	**Income before Income Taxes (line 30 minus line 40)****	909,221	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 909,221	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,373,955	44
45	Private Pay - Net Inpatient Revenue	103,734	45
46	Medicare - Net Inpatient Revenue	203,435	46
47	Other-(specify) Managed Care	(24,088)	47
48	Other-(specify) Part B, Bad Debts, Prior Year Adj	464,914	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,121,950	49

* **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 CTR # 0050336 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	1,984	2,083	$ 75,325	$ 36.16	1
2	Assistant Director of Nursing	1,952	2,128	57,508	27.02	2
3	Registered Nurses	7,802	8,342	234,155	28.07	3
4	Licensed Practical Nurses	23,406	24,715	589,090	23.84	4
5	CNAs & Orderlies	44,306	46,716	533,341	11.42	5
6	CNA Trainees					6
7	Licensed Therapist	366	386	19,018	49.27	7
8	Rehab/Therapy Aides	10,712	11,606	201,292	17.34	8
9	Activity Director	1,796	1,976	23,811	12.05	9
10	Activity Assistants	3,820	4,047	40,573	10.03	10
11	Social Service Workers	9,202	9,937	197,313	19.86	11
12	Dietician					12
13	Food Service Supervisor	2,032	2,142	46,543	21.73	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,349	21,741	209,132	9.62	15
16	Dishwashers					16
17	Maintenance Workers	4,733	5,108	70,374	13.78	17
18	Housekeepers	8,821	9,454	121,714	12.87	18
19	Laundry	8,636	9,441	94,345	9.99	19
20	Administrator	1,984	2,162	117,653	54.42	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,213	11,843	203,820	17.21	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,087	1,109	10,542	9.51	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	164,201	174,936	$ 2,845,549 *	$ 16.27	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	$ 7,869	1.3	35
36	Medical Director	Monthly	14,400	9.3	36
37	Medical Records Consultant	Quarterly	2,905	10.3	37
38	Nurse Consultant			10.3	38
39	Pharmacist Consultant		6,434	10.3	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	78	4,928	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	266	$ 36,536		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 CTR # 0050336 Report Period Beginning: 1/1/12 Ending: 12/31/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
LORENE FOUST	ADMINISTRATOR		$ 117,653
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 117,653

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		$ 251,778
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 251,778

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 81,465
Unemployment Compensation Insurance	101,272
FICA Taxes	209,619
Employee Health Insurance	45,226
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K	864
EMPLOYEE BENEFITS - OTHER	4,434
EMPLOYEE PHYSICAL EXAM	15,186
TOTAL (agree to Schedule V, line 22, col.8)	$ 458,066

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	8,778
Health Care Worker Background Check	2,439
(Indicate # of checks performed 6)	
Patient Background Checks 106	
ADVERTISING & MARKETING	10,250
DUES & SUBSCRIPTIONS	11,169
LICENSES	3,267
ALLOCATION FROM PLATINUM	433
Less: Public Relations Expense	( )
Non-allowable advertising	(10,250)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,086

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,259
ALLOCATION FROM PLATINUM	315
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,574

* Attach copy of IMRF notifications

**See instructions.

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

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 CTR **#** 0050336 **Report Period Beginning:** 1/1/12 **Ending:** 12/31/12

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 $10,637**

(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?

(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? **15 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** 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. $ **413,118**
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. $ **N/A** Has any meal income been offset against related costs? **N/A** 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?
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.