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.

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

I. IDPH License ID Number: 0047035

Facility Name: Mid America Care Center

Address: 4920 N Kenmore Ave (Number) Chicago (City) 60640 (Zip Code)

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 1975

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	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: Steve Lavenda **Telephone Number:** (847) 236-1111
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/13 to 12/31/13 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Cary N. Drazner, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	310	Skilled (SNF)	310	113,150	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	310	TOTALS	310	113,150	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	53,945	1,799	7,231	62,975	8
9	SNF/PED					9
10	ICF	33,917			33,917	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	87,862	1,799	7,231	96,892	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.63%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 310 and days of care provided 5,859

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2013 Fiscal Year: 12/31/2013

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	465,534	83,153	16,489	565,176		565,176	39	565,215			1
2	Food Purchase		594,402		594,402	(60,116)	534,287	(7,557)	526,730			2
3	Housekeeping	484,294	85,441		569,735		569,735	2,361	572,096			3
4	Laundry	222,638	10,522	4,335	237,495		237,495		237,495			4
5	Heat and Other Utilities			265,771	265,771		265,771	(2,684)	263,087			5
6	Maintenance	125,370	24,328	98,117	247,815		247,815	30,539	278,354			6
7	Other (specify):*											7
8	TOTAL General Services	1,297,836	797,846	384,712	2,480,394	(60,116)	2,420,279	22,698	2,442,976			8
	B. Health Care and Programs											
9	Medical Director			69,000	69,000		69,000	26,709	95,709			9
10	Nursing and Medical Records	3,915,912	296,837	305,431	4,518,180		4,518,180	112,600	4,630,780			10
10a	Therapy	274,350		148,072	422,422		422,422		422,422			10a
11	Activities	202,219	15,702	1,210	219,131		219,131		219,131			11
12	Social Services	312,142		19,359	331,501		331,501	3,235	334,736			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							19,597	19,597			15
16	TOTAL Health Care and Programs	4,704,623	312,539	543,072	5,560,234		5,560,234	162,140	5,722,374			16
	C. General Administration											
17	Administrative	220,536		458,124	678,660		678,660	(252,682)	425,978			17
18	Directors Fees											18
19	Professional Services			590,527	590,527	(304)	590,223	(495,403)	94,820			19
20	Dues, Fees, Subscriptions & Promotions			163,809	163,809		163,809	(81,262)	82,547			20
21	Clerical & General Office Expenses	321,021	24,717	627,835	973,573		973,573	(306,274)	667,299			21
22	Employee Benefits & Payroll Taxes			1,092,492	1,092,492	60,116	1,152,608		1,152,608			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,162	3,162		3,162	168	3,330			24
25	Other Admin. Staff Transportation			7,477	7,477		7,477	4,742	12,219			25
26	Insurance-Prop.Liab.Malpractice			357,793	357,793		357,793	(30,321)	327,472			26
27	Other (specify):*							67,199	67,199			27
28	TOTAL General Administration	541,557	24,717	3,301,219	3,867,493	59,812	3,927,305	(1,093,834)	2,833,471			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,544,016	1,135,102	4,229,003	11,908,121	(304)	11,907,817	(908,996)	10,998,821			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mid America Care Center #0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

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			292,351	292,351		292,351	43,124	335,475			30
31	Amortization of Pre-Op. & Org.			4,313	4,313		4,313		4,313			31
32	Interest			477,704	477,704		477,704	(477,704)	0			32
33	Real Estate Taxes			591	591	304	895	351,293	352,188			33
34	Rent-Facility & Grounds			1,320,000	1,320,000		1,320,000	(1,320,000)	(0)			34
35	Rent-Equipment & Vehicles			12,333	12,333		12,333	(1,388)	10,945			35
36	Other (specify):*											36
37	TOTAL Ownership			2,107,292	2,107,292	304	2,107,596	(1,404,675)	702,921			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		236,933	1,162,825	1,399,758		1,399,758	(1,676)	1,398,082			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			722,295	722,295		722,295		722,295			42
43	Other (specify):*	139,103		5,348	144,451		144,451	(144,451)	0			43
44	TOTAL Special Cost Centers	139,103	236,933	1,890,468	2,266,504		2,266,504	(146,127)	2,120,377			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,683,119	1,372,035	8,226,763	16,281,917		16,281,917	(2,459,798)	13,822,119			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(10,667)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(15,325)	30		9
10	Interest and Other Investment Income	(332,209)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,362)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(110)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(365)	21		18
19	Entertainment	(747)	21		19
20	Contributions	(66,310)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(521,397)	21		24
25	Fund Raising, Advertising and Promotional	(29,281)	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	(531,349)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,509,121)		$	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)	(950,676)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (950,676)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (2,459,798)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS **Page 5A**

Mid America Care Center

ID# 0047035

Report Period Beginning: 01/01/13

Ending: 12/31/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (2,563)	02	1
2	Jury Duty	(169)	10	2
3	Marketing Consultant	(5,065)	43	3
4	Bank Charges	(5,682)	21	4
5	Marketing Salaries	(139,103)	43	5
6	Non-Allowable Accounting Fee	(5,000)	19	6
7	Theft & Loss	(1,277)	21	7
8	Sequestration Expense	(34,390)	21	8
9	Building Company Amortization	(20,818)	31	9
10	Building Company Dues & Subscriptions	(175)	20	10
11	Building Company Professional Fees	(9,434)	19	11
12	COPE Dues	(12,644)	20	12
13	Non-Allowable Seminar	(975)	24	13
14	Non-Allowable Travel	(248)	25	14
15	Non-Allowable Legal	(3,686)	19	15
16	Additional R&M	23,627	06	16
17	PPA - Insurance Expense	(44,730)	26	17
18	PPA - Professional Fees	(3,003)	19	18
19	PPA - Marketing Solutions	(283)	43	19
20	Building 4930 Real Estate Tax Expense	(6,306)	33	20
21	Food Rebates	(4,884)	02	21
22	Non-Allowable Auto Lease	(8,227)	35	22
23	Non-Allowable Interest Expense	(243,706)	32	23
24	Capitalized R&M	(2,609)	06	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**	(531,349)		49

Mid America Care Center

ID# 0047035

Report Period Beginning: 01/01/13

Ending: 12/31/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32

82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mid America Care Center # 0047035 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

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			39									39	1
2	Food Purchase	(7,557)											(7,557)	2
3	Housekeeping			2,361									2,361	3
4	Laundry													4
5	Heat and Other Utilities	(10,667)	4,183	2,863		936							(2,684)	5
6	Maintenance	21,018	450	7,357		1,714							30,539	6
7	Other (specify):*													7
8	**TOTAL General Services**	2,794	4,633	12,620		2,650							22,698	8
	B. Health Care and Programs													
9	Medical Director			26,709									26,709	9
10	Nursing and Medical Records	(169)		112,769									112,600	10
10a	Therapy													10a
11	Activities													11
12	Social Services			3,235									3,235	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			19,597									19,597	15
16	**TOTAL Health Care and Programs**	(169)		162,309									162,140	16
	C. General Administration													
17	Administrative			70,347	122,203		(445,232)						(252,682)	17
18	Directors Fees													18
19	Professional Services	(21,123)	9,434	(357,958)	(126,959)	1,203							(495,403)	19
20	Fees, Subscriptions & Promotions	(108,410)	175	26,656		199	118						(81,262)	20
21	Clerical & General Office Expenses	(565,220)	(15,051)	273,887	50	60							(306,274)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(975)		1,142									168	24
25	Other Admin. Staff Transportation	(248)		3,012	5		1,973						4,742	25
26	Insurance-Prop.Liab.Malpractice	(44,730)	13,183	767		459							(30,321)	26
27	Other (specify):*			56,037	11,161								67,199	27
28	**TOTAL General Administration**	(740,705)	7,741	73,890	6,460	1,922	(443,141)						(1,093,834)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(738,080)	12,374	248,819	6,460	4,572	(443,141)						(908,996)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mid America Care Center # 0047035 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

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	(15,325)	33,593	19,262		5,593							43,124	30
31	Amortization of Pre-Op. & Org.	(20,818)	20,818											31
32	Interest	(575,915)	87,791	69		10,352							(477,704)	32
33	Real Estate Taxes	(6,306)	352,480			5,119							351,293	33
34	Rent-Facility & Grounds		(1,320,000)	30,265		(30,265)							(1,320,000)	34
35	Rent-Equipment & Vehicles	(8,227)		318	6,521								(1,388)	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(626,591)	(825,318)	49,914	6,521	(9,201)							(1,404,675)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(1,676)					(1,676)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(144,451)											(144,451)	43
44	**TOTAL Special Cost Centers**	(144,451)						(1,676)					(146,127)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,509,121)	(812,944)	298,733	12,981	(4,629)	(443,141)	(1,676)					(2,459,798)	45

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent Income	$ 1,320,000	Mid America Convalescent Center, Inc.	100.00%	$	$ (1,320,000)	1
2	V	21	Miscellaneous Income		Mid America Convalescent Center, Inc.	100.00%			2
3	V	32	Interest	600,660	Mid America Convalescent Center, Inc.	100.00%	688,451	87,791	3
4	V	21	Prior Period Adjustment	15,051	Mid America Convalescent Center, Inc.	100.00%		(15,051)	4
5	V	31	Amortization		Mid America Convalescent Center, Inc.	100.00%	20,818	20,818	5
6	V	33	Real Estate Taxes		Mid America Convalescent Center, Inc.	100.00%	352,480	352,480	6
7	V	20	Dues & Subscriptions		Mid America Convalescent Center, Inc.	100.00%	175	175	7
8	V	06	Scavenger & Exterminator		Mid America Convalescent Center, Inc.	100.00%	450	450	8
9	V	26	Multiperil Insurance		Mid America Convalescent Center, Inc.	100.00%	13,183	13,183	9
10	V	19	Professional Fees		Mid America Convalescent Center, Inc.	100.00%	9,434	9,434	10
11	V	05	Utilities		Mid America Convalescent Center, Inc.	100.00%	4,183	4,183	11
12	V	30	Depreciation		Mid America Convalescent Center, Inc.	100.00%	33,593	33,593	12
13	V								13
14	Total			$ 1,935,711			$ 1,122,767	$ * (812,944)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	MANAGCARE, INC.	100.00%	$ 39	$ 39	15
16	V	3	HOUSEKEEPING		MANAGCARE, INC.	100.00%	2,361	2,361	16
17	V	5	UTILITIES		MANAGCARE, INC.	100.00%	2,863	2,863	17
18	V	6	REPAIRS AND MAINT.		MANAGCARE, INC.	100.00%	7,357	7,357	18
19	V	9	MEDICAL DIRECTOR		MANAGCARE, INC.	100.00%	26,709	26,709	19
20	V	10	NURSING SALARIES		MANAGCARE, INC.	100.00%	112,769	112,769	20
21	V	12	SOCIAL SERVICE SALARIES		MANAGCARE, INC.	100.00%	3,235	3,235	21
22	V	15	NURSING EMP BENS & PR TAXES		MANAGCARE, INC.	100.00%	19,597	19,597	22
23	V	17	ADMINISTRATIVE SALARIES		MANAGCARE, INC.	100.00%	70,347	70,347	23
24	V	19	PROFESSIONAL FEES		MANAGCARE, INC.	100.00%	2,546	2,546	24
25	V	20	FEES, SUBSCRIPTIONS		MANAGCARE, INC.	100.00%	26,656	26,656	25
26	V	21	CLERICAL AND GENERAL SALARIES		MANAGCARE, INC.	100.00%	206,115	206,115	26
27	V	21	CLERICAL AND GENERAL EXP		MANAGCARE, INC.	100.00%	67,772	67,772	27
28	V	24	SEMINARS		MANAGCARE, INC.	100.00%	1,142	1,142	28
29	V	25	ADMIN. STAFF TRANS.		MANAGCARE, INC.	100.00%	3,012	3,012	29
30	V	26	INSURANCE		MANAGCARE, INC.	100.00%	767	767	30
31	V	27	GEN. ADMIN. EMP. BEN.		MANAGCARE, INC.	100.00%	56,037	56,037	31
32	V	30	DEPRECIATION		MANAGCARE, INC.	100.00%	19,262	19,262	32
33	V	32	INTEREST EXPENSE		MANAGCARE, INC.	100.00%	69	69	33
34	V	34	RENT - BUILDING (RELATED)		MANAGCARE, INC.	100.00%	30,265	30,265	34
35	V	35	EQUIPMENT RENTAL		MANAGCARE, INC.	100.00%	318	318	35
36	V								36
37	V	19	BOOKKEEPING	360,504	MANAGCARE, INC.			(360,504)	37
38	V								38
39	Total			$ 360,504			$ 659,237	$ * 298,733	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE SALARY - NATH	$	TETRAD MANAGEMENT, LLC	100.00%	$ 37,922	$ 37,922	15
16	V	17	ADMINISTRATIVE SALARY - JOSH DAVIS		TETRAD MANAGEMENT, LLC	100.00%	13,033	13,033	16
17	V	17	ADMINISTRATIVE SALARY - MOSHE DAVIS		TETRAD MANAGEMENT, LLC	100.00%	37,922	37,922	17
18	V	17	ADMINISTRATIVE FEES - YOSEF DAVIS		TETRAD MANAGEMENT, LLC	100.00%	33,326	33,326	18
19	V	17	TOTAL MANAGEMENT FEES		TETRAD MANAGEMENT, LLC	100.00%			19
20	V	19	PROFESSIONAL FEES		TETRAD MANAGEMENT, LLC	100.00%	299	299	20
21	V	21	OFFICE EXPENSE		TETRAD MANAGEMENT, LLC	100.00%	50	50	21
22	V	25	TRAVEL		TETRAD MANAGEMENT, LLC	100.00%	5	5	22
23	V	27	EMPLOYEE BEENFITS- PAYROLL TAXES		TETRAD MANAGEMENT, LLC	100.00%	11,161	11,161	23
24	V	35	AUTO LEASE EXPENSE		TETRAD MANAGEMENT, LLC	100.00%	6,521	6,521	24
25	V								25
26	V	19	ADMIN CONSULTANT	127,258	TETRAD MANAGEMENT, LLC			(127,258)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 127,258			$ 140,239	$ * 12,981	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	4600 TOUHY, LLC	100.00%	$ 936	$ 936	15
16	V	6	REPAIRS & MAINT.		4600 TOUHY, LLC	100.00%	1,714	1,714	16
17	V	19	PROFESSIONAL FEES		4600 TOUHY, LLC	100.00%	1,203	1,203	17
18	V	20	FEES, SUBSCRIPTIONS		4600 TOUHY, LLC	100.00%	199	199	18
19	V	21	CLERICAL & GENERAL		4600 TOUHY, LLC	100.00%	60	60	19
20	V	26	INSURANCE		4600 TOUHY, LLC	100.00%	459	459	20
21	V	30	DEPRECIATION		4600 TOUHY, LLC	100.00%	5,593	5,593	21
22	V	32	INTEREST EXPENSE		4600 TOUHY, LLC	100.00%	10,352	10,352	22
23	V	33	REAL ESTATE TAXES		4600 TOUHY, LLC	100.00%	5,119	5,119	23
24	V								24
25	V								25
26	V	34	RENT	30,265	4600 TOUHY, LLC			(30,265)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 30,265			$ 25,636	$ * (4,629)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$	INTERCARE, LTD. C/O MANAGCARE	100.00%	$ 12,892	$ 12,892	15
16	V								16
17	V	20	FEES, SUBSCRIPTIONS		INTERCARE, LTD. C/O MANAGCARE	100.00%	118	118	17
18	V								18
19	V	25	ADMIN. STAFF TRAVEL		INTERCARE, LTD. C/O MANAGCARE	100.00%	1,973	1,973	19
20	V								20
21	V	17	MANAGEMENT FEES	458,124	INTERCARE, LTD. C/O MANAGCARE	100.00%		(458,124)	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 458,124			$ 14,983	$ * (443,141)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	39	Ambulance	$ 9,585	Lifeline Ambulance	100.00%	$ 7,909	$ (1,676)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 9,585			$ 7,909	$ * (1,676)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	AHUVA WEINREB	0.590%	BRIGHTVIEW CARE CENTER, INC	CHICAGO	MID AMERICA CONVALESCENT CENTER, INC.		BUILDING CO.	1
2	DAVIS FAMILY TRUST	35.918%	LAKE SHORE HEALTHCARE & REHABILITATION CENTRE,LLC	CHICAGO	4600 Touhy LLC		BUILDING CO.	2
3	EDIE DAVIS	0.672%	MAYFIELD CARE CENTER, INC.	CHICAGO	MANAGCARE, INC.		MANAGEMENT CO.	3
4	ELIYAHU DAVIS	0.590%	CAPITOL HEALTHCARE & REHABILITATION CENTRE	SPRINGFIELD, IL	INTERCARE, LTD. C/O MANAGCARE		MANAGEMENT CO.	4
5	MOSHE Y. DAVIS	0.590%	COLONIAL HEALTHCARE & REHABILITATION CENTRE	PRINCETON, IL	TETRAD MANAGEMENT, LLC		MANAGEMENT CO.	5
6	NESANEL B. DAVIS	0.590%	THE HEIGHTS HEALTHCARE & REHABILITATION CENTRE	PEORIA HEIGHTS, IL	LIFELINE AMBULANCE,LLC		AMBULANCE	6
7	SHOSHANA BRAUN	0.590%	MORTON VILLA HEALTHCARE & REHABILTATION CENTRE	MORTON, IL				7
8	YEHOSHUA B. DAVIS	0.590%	MORTON TERRACE HEALTHCARE & REHABILITATION CENTRE	MORTON, IL				8
9	YISROEL M. DAVIS	0.590%	RIVERSHORES HEALTHCARE 7 REHABILTATION CENTRE	MASEILLES, IL				9
10	YOSEF DAVIS	0.059%						10
11	YOSEF DAVIS DELTA TRUST	59.221%						11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Davis	Shareholder	Administrative	0.059%	See Attached	3.58	11.93%	Mgt Fees/Sal	$ 46,218	17-7	1
2	Yehoshua Davis	Shareholder	Administrative	0.590%	See Attached	9.56	19.92%	Sal/Al. Sal	138,033	17-1;17-1	2
3	Moshe Davis	Shareholder	Administrative	0.590%	See Attached	8.76	19.91%	Alloc Salary	37,922	17-7	3
4	Nesaniel Davis	Shareholder	Administrative	0.590%	See Attached	9.56	19.92%	Alloc Salary	37,922	17-7	4
5	Eli Davis	Shareholder	Administrative	0.590%	See Attached	7.96	19.90%	Alloc Salary	1,394	17-7	5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 261,489		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	PATIENT DAYS	486,626	10	$ 198	$	96,892	$ 39	1
2	3	HOUSEKEEPING	PATIENT DAYS	486,626	10	11,856		96,892	2,361	2
3	5	UTILITIES	PATIENT DAYS	486,626	10	14,381		96,892	2,863	3
4	6	REPAIRS AND MAINT.	PATIENT DAYS	486,626	10	36,948		96,892	7,357	4
5	9	MEDICAL DIRECTOR	PATIENT DAYS	486,626	10	134,142		96,892	26,709	5
6	10	NURSING SALARIES	PATIENT DAYS	486,626	10	566,366	566,366	96,892	112,769	6
7	12	SOCIAL SERVICE SALARIES	PATIENT DAYS	486,626	10	16,247	16,247	96,892	3,235	7
8	15	NURSING EMP BENS & PR TA	PATIENT DAYS	486,626	10	98,421		96,892	19,597	8
9	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	486,626	10	353,309	353,309	96,892	70,347	9
10	19	PROFESSIONAL FEES	PATIENT DAYS	486,626	10	12,785		96,892	2,546	10
11	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	486,626	10	133,874		96,892	26,656	11
12	21	CLERICAL AND GENERAL SA	PATIENT DAYS	486,626	10	1,035,183	1,035,183	96,892	206,115	12
13	21	CLERICAL AND GENERAL EX	PATIENT DAYS	486,626	10	340,374		96,892	67,772	13
14	24	SEMINARS	PATIENT DAYS	486,626	10	5,737		96,892	1,142	14
15	25	ADMIN. STAFF TRANS.	PATIENT DAYS	486,626	10	15,128		96,892	3,012	15
16	26	INSURANCE	PATIENT DAYS	486,626	10	3,851		96,892	767	16
17	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	486,626	10	281,440		96,892	56,037	17
18	30	DEPRECIATION	PATIENT DAYS	486,626	10	96,741		96,892	19,262	18
19	32	INTEREST EXPENSE	PATIENT DAYS	486,626	10	346		96,892	69	19
20	34	RENT - BUILDING (RELATED)	PATIENT DAYS	486,626	10	152,000		96,892	30,265	20
21	35	EQUIPMENT RENTAL	PATIENT DAYS	486,626	10	1,597		96,892	318	21
22										22
23										23
24										24
25	TOTALS					$ 3,310,923	$ 1,971,105		$ 659,237	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE SALARY -	PATIENT DAYS	486,626	10	$ 190,457	$ 190,457	96,892	$ 37,922	1
2	17	ADMINISTRATIVE SALARY -	PATIENT DAYS	486,626	10	65,457	65,457	96,892	13,033	2
3	17	ADMINISTRATIVE SALARY -	PATIENT DAYS	486,626	10	190,457	190,457	96,892	37,922	3
4	17	ADMINISTRATIVE FEES - YO	PATIENT DAYS	486,626	10	167,375		96,892	33,326	4
5	17	TOTAL MANAGEMENT FEES	PATIENT DAYS	486,626	10			96,892		5
6	19	PROFESSIONAL FEES	PATIENT DAYS	486,626	10	1,500		96,892	299	6
7	21	OFFICE EXPENSE	PATIENT DAYS	486,626	10	253		96,892	50	7
8	25	TRAVEL	PATIENT DAYS	486,626	10	23		96,892	5	8
9	27	EMPLOYEE BEENFITS- PAYF	PATIENT DAYS	486,626	10	56,057		96,892	11,161	9
10	35	AUTO LEASE EXPENSE	PATIENT DAYS	486,626	10	32,750		96,892	6,521	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 704,328	$ 446,371		$ 140,239	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

	1 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	MNGCR. PATIENT DAYS	486,626	10	$ 4,702	$	96,892	$ 936	1
2	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS	486,626	10	8,610		96,892	1,714	2
3	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS	486,626	10	6,043		96,892	1,203	3
4	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS	486,626	10	1,001		96,892	199	4
5	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS	486,626	10	300		96,892	60	5
6	26	INSURANCE	MNGCR. PATIENT DAYS	486,626	10	2,308		96,892	459	6
7	30	DEPRECIATION	MNGCR. PATIENT DAYS	486,626	10	28,092		96,892	5,593	7
8	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS	486,626	10	51,990		96,892	10,352	8
9	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS	486,626	10	25,708		96,892	5,119	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 128,752	$		$ 25,636	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	AVG. HOURS WORKED	187,889	3	$ 25,000	$ 25,000	96,892	$ 12,892	1
2										2
3	20	FEES, SUBSCRIPTIONS	AVG. HOURS WORKED	187,889	3	228		96,892	118	3
4										4
5	25	ADMIN. STAFF TRAVEL	AVG. HOURS WORKED	187,889	3	3,826		96,892	1,973	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 29,054	$ 25,000		$ 14,983	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

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: Lifeline Ambulance LLC
Street Address: 2424 S. Wabash Ave
City / State / Zip Code: Chicago, IL 60616
Phone Number: (312) 949-9595
Fax Number: (312) 9499262

	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	39	Ambulance	Direct Allocation			$	$		$ 7,909	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 7,909	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	MB Financial			Mortgage			$	$ 4,900,000			$	1
2	MB Financial			Mortgage				14,000,000			688,451	2
3												3
4												4
5												5
	Working Capital											
6	MB Financial			Line of Credit				2,445,686			232,098	6
7	Volkswagon Financial			Auto Financing				5,854				7
8	See Supplemental Schedule							7,589,276			12,321	8
9	TOTAL Facility Related						$	$ 28,940,816			$ 932,870	9
	B. Non-Facility Related*											
10	Interest Income		X								(269,902)	10
11	Interest Income- Bldg. Co.		X								(600,660)	11
12	Misc. Interest Expense		X								(62,308)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (932,870)	14
15	TOTALS (line 9+line14)						$	$ 28,940,816			$ (0)	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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	GMAC		X				$	$ 5,018			$	8
9	Allocated From Managcare		X								69	9
10	Allocated From 4600 Touhy		X								10,352	10
11	Surety Bond		X								1,900	11
12	Due to Related Parties	X						7,584,258			243,706	12
13	Non-Allowable Interest	X									(243,706)	13
14	TOTAL Working Capital							7,589,276			12,321	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	299,500	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.)	$	321,884	2
3. Under or (over) accrual (line 2 minus line 1).	$	22,384	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)	$	329,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	304	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** $ 646 **For** 2000, '03 **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.	$	352,188	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2008	315,230	8
2009	275,465	9
2010	287,457	10
2011	286,262	11
2012	316,765	12

2013 Accrual = $316,765 + 6306 (non-care bill) x 1.02 = $329,500 (rounded)

Allocation From 4600 Touhy LLC: $5119

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mid America Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0047035

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-08-410-017-0000	Long Term Care Property	$ 6,305.94	$
2.	14-08-410-018-0000	Long Term Care Property	$ 86,749.46	$ 86,749.46
3.	14-08-410-019-0000	Long Term Care Property	$ 86,749.46	$ 86,749.46
4.	14-08-410-020-0000	Long Term Care Property	$ 86,749.46	$ 86,749.46
5.	14-08-410-021-0000	Long Term Care Property	$ 56,516.78	$ 56,516.78
6.	See Attached	Allocated From 4600 Touhy LLC	$ 48,715.81	$ 4,849.90
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 371,786.91	$ 321,615.06

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation 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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

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

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mid America Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0047035

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$

4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 94,500 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

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

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

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

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

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

None

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

1. Total Amount Incurred: 21,565
2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 4,313
4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	94,500	1979	$ 307,874	1
2					2
3	TOTALS	94,500		$ 307,874	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	310			1975	$ 3,258,613	$ 33,593		$	$ (33,593)	$ 3,258,613	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1978	2,575		20			2,575	9
10	Various			1979	33,995		20			33,995	10
11	Various			1980	13,673		20			13,673	11
12	Various			1981	107,932		20			107,932	12
13	Various			1982	4,750		20			4,750	13
14	Various			1983	1,787		20			1,787	14
15	Various			1984	25,291		20			25,042	15
16	Various			1985	17,828		20			17,679	16
17	Various			1986	62,698		20			62,650	17
18	Various			1987	18,422		20			18,382	18
19	Various			1988	33,825		20	375	375	33,825	19
20	Various			1989	23,916		20	226	226	23,752	20
21	Various			1990	23,550		20			23,550	21
22	Various			1991	20,020		20			11,918	22
23	Various			1992	51,260		20			50,421	23
24	Various			1993	7,134		20	37	37	7,132	24
25	Various			1994	32,273		20	1,614	1,614	31,088	25
26	Various			1995	227,831		20	11,236	11,236	211,188	26
27	Various			1996	136,732		20	6,809	6,809	120,103	27
28	Various			1997	26,804		20	1,340	1,340	22,164	28
29	Various			1998	81,506		20	4,075	4,075	62,988	29
30	Various			1999	113,499		20	5,675	5,675	82,428	30
31	Various			2000	308,605		20	15,262	15,262	209,575	31
32	Various			2001	56,517		20	2,826	2,826	35,368	32
33	Various			2002	66,827		20	863	863	60,134	33
34	Various			2003	33,074		20	1,965	1,965	27,837	34
35	Various			2004	12,735		20	753	753	8,356	35
36	Various			2005	13,227		20	1,213	1,213	9,889	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Various	2006	$ 34,488	$	20	$ 1,967	$ 1,967	$ 19,851	37
38	Various	2007	118,844		20	9,791	9,791	83,132	38
39	Various	2008	127,264		20	11,198	11,198	58,323	39
40	Various	2009	381,167		20	29,839	29,839	130,009	40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
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57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		209,430	8,859		8,768	(91)	17,825	68
69	Financial Statement Depreciation			292,351			(292,351)		69
70	TOTAL (lines 4 thru 69)		$ 5,688,093	$ 334,803		$ 115,831	$ (218,972)	$ 4,887,935	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,688,093	$ 334,803		$ 115,831	$ (218,972)	$ 4,887,935	1
2	Exhaust Manifold	2010	3,162		20	158	158	580	2
3	Sprinkler System Repair	2010	3,653		20	183	183	578	3
4	5Th Floor Corridor: Cove Base And Handrail Installation. Reside	2010	66,261		20	3,313	3,313	10,215	4
5	Galvanized Piping	2011	8,750		20	875	875	2,552	5
6	Epoxy Quartz Flooring	2011	22,000		20	1,467	1,467	4,156	6
7	Aluminum Double Hung Windows	2011	191,328		20	19,133	19,133	49,426	7
8	Custom Shaped Canopy	2011	6,080		20	1,216	1,216	3,040	8
9	Fire Rated Access Doors	2011	3,527		20	353	353	852	9
10	Custom Sign	2011	5,651		20	565	565	1,319	10
11	Elevator Wraps	2011	7,608		20	380	380	1,078	11
12	Kitchen Dish Room Flooring	2012	4,900		20	327	327	653	12
13	Furnish And Install Footing, Steel And Concrete Slab	2012	7,500		20	750	750	1,500	13
14	Install Emergency Generator	2012	221,840		20	11,000	11,000	16,500	14
15	Repair Water Chiller	2012	5,944		20	594	594	991	15
16	4Th Fl Dayroom- Wallcovering, Painting, Window Treatments	2012	6,784		20	1,225	1,225	2,450	16
17	4Th Fl Dayroom:Wallcoverings,Handrails,Bump.Guards,Window	2012	162,781		20				17
18	Roof Patching And Wall Flashing	2012	3,200		20	160	160	320	18
19	Asphalt Surface Sealing	2012	3,170		20	159	159	317	19
20	Med Room Doors On All 5 Floors	2013	7,767		20	777	777	777	20
21	Fire Alarm System	2013	3,133		20	313	313	313	21
22	5 Metal Door Frames On 2Nd, 3Rd, 4Th, 5Th, 6Th Floors	2013	6,100		20	559	559	559	22
23	2Nd Floor Bed Outlets	2013	13,500		20	1,013	1,013	1,013	23
24	Stairway Handrail	2013	7,250		20	725	725	725	24
25	Chiller Repair	2013	6,522		20	272	272	272	25
26	Drain Piping Repair - North And South Walls	2013	3,460		20	115	115	115	26
27	Doors For 6Th Floor Oxygen Rooms	2013	2,609		20	130	130	130	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,472,573	$ 334,803		$ 161,592	$ (173,211)	$ 4,988,366	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 6,472,573	$ 334,803		$ 161,592	$ (173,211)	$ 4,988,366	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,472,573	$ 334,803		$ 161,592	$ (173,211)	$ 4,988,366	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 6,472,573	$ 334,803		$ 161,592	$ (173,211)	$ 4,988,366	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,472,573	$ 334,803		$ 161,592	$ (173,211)	$ 4,988,366	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 6,472,573	$ 334,803		$ 161,592	$ (173,211)	$ 4,988,366	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,472,573	$ 334,803		$ 161,592	$ (173,211)	$ 4,988,366	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information Continued		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		$	$		$	$	$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Buildings:								3
4	Allocated From 4600 Touhy LLC	2012	102,234	2,621	20	3,408	787	6,816	4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated From 4600 Touhy LLC								9
10	Allocated From 4600 Touhy LLC	2012	65,839	1,721	20	3,292	1,571	6,584	10
11		2013	16,020	1,251	20	801	(450)	801	11
12	Allocated From Managcare								12
13	Allocated From Managcare	2013	1,716	978	20	86	(892)	86	13
14		2012	21,345	2,288	20	1,067	(1,221)	2,134	14
15	Allocated From Intercare								15
16		2001	2,276		20	114	114	1,404	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information Continued		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 209,430	$ 8,859		$ 8,768	$ (91)	$ 17,825	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	$ 1,112,371	$ 4,641	$ 157,733	$ 153,092	10	$ 675,418	71
72	Current Year Purchases	117,436	9,859	9,648	(211)	10	9,648	72
73	Fully Depreciated Assets	1,070,608		20	20	10	1,070,608	73
74								74
75	TOTALS	$ 2,300,414	$ 14,500	$ 167,401	$ 152,901		$ 1,755,674	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		2010 Volkswagen Tiguan	2010	$ 22,507	$	$ 3,750	$ 3,750	5	$ 16,882	76
77		Allocated From Managcare	2013	24,064		2,731	2,731	5	19,273	77
78										78
79					1,495		(1,495)			79
80	TOTALS			$ 46,571	$ 1,495	$ 6,481	$ 4,986		$ 36,155	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)	$ 9,127,432	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 350,798	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 335,473	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (15,325)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,780,195	85	

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	1994 ALTIMA - 1994	$ 17,799	$	$	86
87	4930 BLDG - 1998	159,035			87
88	4930 LAND - 1998	17,500			88
89					89
90					90
91	TOTALS	$ 194,334	$	$	91

G. Construction-in-Progress

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2014	$
13.	/2015	$
14.	/2016	$

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: $ 318 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	Facility	2013 Toyota Rav 4UT	$	$ 4,106	17
18	Allocated From Tetrad Management			6,521	18
19					19
20					20
21	TOTAL		$	$ 10,627	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	39 - 03	hrs	$		$ 437,782	$		$ 437,782	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			90,665			90,665	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			462,778			462,778	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				214,660		214,660	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					171,600	22,273		193,873	13
14	TOTAL			$		$ 1,162,825	$ 236,933		$ 1,399,758	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13 (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	$ 730,894	$ 1,279,347	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,447,838	4,485,152	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	231,118	243,012	6
7	Other Prepaid Expenses	120,220	120,220	7
8	Accounts Receivable (owners or related parties)	2,946,382	18,972,416	8
9	Other(specify): See Attached Schedule	5,589,527	5,723,455	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 14,065,979	$ 30,823,602	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		325,374	13
14	Buildings, at Historical Cost		3,417,648	14
15	Leasehold Improvements, at Historical Cost	1,625,935	3,111,672	15
16	Equipment, at Historical Cost	1,078,105	2,338,124	16
17	Accumulated Depreciation (book methods)	(1,136,133)	(6,613,712)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	49,166	1,104,616	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,617,073	$ 3,683,722	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 15,683,052	$ 34,507,324	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,223,978	$ 1,240,917	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	55,774	55,774	28
29	Short-Term Notes Payable	10,040,816	10,040,816	29
30	Accrued Salaries Payable	457,048	457,048	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,566	8,566	31
32	Accrued Real Estate Taxes(Sch.IX-B)		329,500	32
33	Accrued Interest Payable	19,280	45,724	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	511,713	682,328	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 12,317,175	$ 12,860,673	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		4,900,000	39
40	Mortgage Payable		14,000,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 18,900,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 12,317,175	$ 31,760,673	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,365,877	$ 2,746,651	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 15,683,052	$ 34,507,324	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,004,254	1	
2	Restatements (describe):		2	
3	**Replacement Tax**	(19,000)	3	
4	**Additional Rent**	(70,000)	4	
5	**Misc.**	(36)	5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,915,218	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,250,659	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(1,800,000)	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)**	$ (549,341)	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)**	$ 3,365,877	24	*

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	$ 18,486,380	1
2	Discounts and Allowances for all Levels	(3,584,952)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 14,901,428	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,939,165	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,939,165	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	264,046	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	24,112	19
20	Radiology and X-Ray	2,820	20
21	Other Medical Services	22,534	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 313,512	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	368,847	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 368,847	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	9,624	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 9,624	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 17,532,576	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,480,394	31
32	Health Care	5,560,234	32
33	General Administration	3,867,493	33
	B. Capital Expense		
34	Ownership	2,107,292	34
	C. Ancillary Expense		
35	Special Cost Centers	1,544,209	35
36	Provider Participation Fee	722,295	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 16,281,917	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,250,659	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,250,659	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 12,427,499	44
45	Private Pay - Net Inpatient Revenue	403,801	45
46	Medicare - Net Inpatient Revenue	1,973,248	46
47	Other-(specify)	96,880	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 14,901,428	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	1,968	2,134	$ 106,588	$ 49.95	1
2	Assistant Director of Nursing	3,821	4,168	168,591	40.45	2
3	Registered Nurses	37,854	40,290	1,151,863	28.59	3
4	Licensed Practical Nurses	33,561	36,627	945,071	25.80	4
5	CNAs & Orderlies	122,451	135,312	1,480,408	10.94	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	14,763	16,667	274,350	16.46	8
9	Activity Director	1,797	2,020	36,637	18.14	9
10	Activity Assistants	14,604	16,497	165,582	10.04	10
11	Social Service Workers	16,265	18,083	312,142	17.26	11
12	Dietician					12
13	Food Service Supervisor	8,592	9,589	153,397	16.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	27,578	30,140	312,137	10.36	15
16	Dishwashers					16
17	Maintenance Workers	5,681	6,373	125,370	19.67	17
18	Housekeepers	41,106	45,491	484,294	10.65	18
19	Laundry	21,460	23,770	222,638	9.37	19
20	Administrator	2,080	2,080	125,000	60.10	20
21	Assistant Administrator	1,808	1,840	95,536	51.92	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	25,000	27,912	321,021	11.50	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,876	4,226	63,391	15.00	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	3,504	4,144	139,103	33.57	33
34	TOTAL (lines 1 - 33)	387,769	427,363	$ 6,683,119 *	$ 15.64	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	358	$ 16,489	01-03	35
36	Medical Director	Monthly	69,000	09-03	36
37	Medical Records Consultant	32	1,536	10-03	37
38	Nurse Consultant	Monthly	236,577	10-03	38
39	Pharmacist Consultant	Monthly	18,958	10-03	39
40	Physical Therapy Consultant	0.25	16	10a-03	40
41	Occupational Therapy Consultant	43	3,331	10a-03	41
42	Respiratory Therapy Consultant	9	499	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	12	1,210	11-03	44
45	Social Service Consultant	408	19,359	12-03	45
46	Other(specify)				46
47	Renal Therapy Consultant	Monthly	144,226	10a-03	47
48	MDS Consultant	Monthly	48,360	10-03	48
49	TOTAL (lines 35 - 48)	862	$ 559,561		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Yehoshua Davis	Administrator	0.590%	$ 125,000
Michael Applebaum	Asst. Admin.	0.00%	95,536
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 220,536

B. Administrative - Other

Description	Amount
Management Fees- Intercare	$ 458,124
TOTAL (agree to Schedule V, line 17, col. 3)	$ 458,124
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	$ 21,641
Frost, Ruttenberg & Rothblatt	Accounting	21,041
Personnel Planners	Unemployment Consult	1,821
Managcare	Bookkeeping	360,504
Tetrad Management LLC	Administrative Consultant	127,258
Achieve Accreditation	Insurance Consultant	7,637
American Data	Computer Services	6,000
E-Health	Computer Services	4,750
CRS	Reimbursement Consult	4,500
LTC Consulting Services	Healthcare Consulting	8,544
Michigan Peer Review Org	Conflict Resolution	585
See Supplemental Schedule		26,246
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 590,526

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 157,694
Unemployment Compensation Insurance	28,137
FICA Taxes	475,049
Employee Health Insurance	312,717
Employee Meals	60,116
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	
Disability Insurance	6,749
Holiday Expense	14,787
Pension Expense	57,550
Other Employee Benefits	39,808
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,152,607

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	8,500
Health Care Worker Background Check	
(Indicate # of checks performed 30)	1,073
Patient Background Checks 207	4,174
Licenses & Permits	5,073
Dues & Subscriptions	36,753
Advertising	29,031
Allocated From Manacare	26,656
See Supplemental Schedule	317
Less: Public Relations Expense	( )
Non-allowable advertising	(29,031)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 82,547

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,187
Allocated from Managcare	1,142
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,329

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/13 Ending: 12/31/13

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on LTC- $30,043**

(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. $ **46,200** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **722,295**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **60,116** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% ln 14**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.