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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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 01/01/14 to 12/31/14 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

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	54,313	1,895	6,904	63,112	8
9	SNF/PED					9
10	ICF	34,149			34,149	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	88,462	1,895	6,904	97,261	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.96%

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 [ ] NO [X]

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 5,105

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: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	461,332	181,700	26,858	669,890		669,890	149	670,039			1
2	Food Purchase		495,632		495,632	(49,604)	446,029	(3,505)	442,524			2
3	Housekeeping	470,383	80,430		550,813		550,813	2,527	553,340			3
4	Laundry	215,910	19,001	2,764	237,675		237,675		237,675			4
5	Heat and Other Utilities			280,020	280,020		280,020	(8,111)	271,909			5
6	Maintenance	128,872	28,502	188,836	346,210		346,210	(25,639)	320,571			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,276,497	805,265	498,478	2,580,240	(49,604)	2,530,637	(34,579)	2,496,058			8
	B. Health Care and Programs											
9	Medical Director			66,120	66,120		66,120	14,596	80,716			9
10	Nursing and Medical Records	4,032,999	324,154	154,775	4,511,928		4,511,928	9,136	4,521,064			10
10a	Therapy	144,862		160,429	305,291		305,291		305,291			10a
11	Activities	204,849	9,655	1,525	216,029		216,029	27	216,056			11
12	Social Services	279,692		18,640	298,332		298,332	9,911	308,243			12
13	CNA Training											13
14	Program Transportation			21,595	21,595		21,595	(2,292)	19,303			14
15	Other (specify):*							9,802	9,802			15
16	**TOTAL Health Care and Programs**	4,662,402	333,809	423,084	5,419,295		5,419,295	41,180	5,460,475			16
	C. General Administration											
17	Administrative	107,167		458,124	565,291		565,291	(66,113)	499,178			17
18	Directors Fees											18
19	Professional Services			951,344	951,344	(1,447)	949,897	(609,317)	340,580			19
20	Dues, Fees, Subscriptions & Promotions			205,289	205,289		205,289	(134,947)	70,342			20
21	Clerical & General Office Expenses	478,199	23,393	522,237	1,023,829		1,023,829	(252,635)	771,194			21
22	Employee Benefits & Payroll Taxes			1,103,131	1,103,131	49,604	1,152,735		1,152,735			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,407	1,407		1,407	294	1,701			24
25	Other Admin. Staff Transportation			11,530	11,530		11,530	6,288	17,818			25
26	Insurance-Prop.Liab.Malpractice			355,329	355,329		355,329	25,026	380,355			26
27	Other (specify):*							86,113	86,113			27
28	**TOTAL General Administration**	585,366	23,393	3,608,391	4,217,150	48,157	4,265,307	(945,292)	3,320,015			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,524,265	1,162,467	4,529,953	12,216,685	(1,447)	12,215,238	(938,690)	11,276,548			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Mid America Care Center #0047035 Report Period Beginning: 01/01/14 Ending: 12/31/14

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			298,218	298,218		298,218	26,332	324,550			30
31	Amortization of Pre-Op. & Org.			4,313	4,313		4,313	(4,313)				31
32	Interest			258,137	258,137		258,137	(227,550)	30,587			32
33	Real Estate Taxes					1,447	1,447	339,700	341,147			33
34	Rent-Facility & Grounds			1,320,000	1,320,000		1,320,000	(1,320,000)				34
35	Rent-Equipment & Vehicles			4,543	4,543		4,543	801	5,344			35
36	Other (specify):*											36
37	TOTAL Ownership			1,885,211	1,885,211	1,447	1,886,658	(1,185,030)	701,628			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		267,802	1,152,236	1,420,038		1,420,038		1,420,038			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			726,927	726,927		726,927		726,927			42
43	Other (specify):*	167,937		57,400	225,337		225,337	(225,337)				43
44	TOTAL Special Cost Centers	167,937	267,802	1,936,563	2,372,302		2,372,302	(225,337)	2,146,965			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,692,202	1,430,269	8,351,727	16,474,198	(0)	16,474,198	(2,349,057)	14,125,141			45

THE TOTAL FOR COLUMN 5 MUST BE ZERO,PLEASE CORRECT

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

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	(13,069)	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	(23,522)	30		9
10	Interest and Other Investment Income	(287,227)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(95)	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	(1,745)	21		18
19	Entertainment				19
20	Contributions	(81,259)	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	(354,246)	21		24
25	Fund Raising, Advertising and Promotional	(38,842)	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	(488,252)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,288,257)		$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,060,800)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,060,800)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (2,349,057)		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

STATE OF ILLINOIS **Page 5A**

Mid America Care Center

ID# 0047035

Report Period Beginning: 01/01/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (3,410)	02	1
2	Jury Duty	(34)	10	2
3	Marketing Consultant	(57,400)	43	3
4	Bank Charges	(5,201)	21	4
5	Marketing Salaries	(167,937)	43	5
6	Theft & Loss	(2,337)	21	6
7	Sequestration Expense	(67,019)	21	7
8	Amortization	(4,313)	31	8
9	Non-Allowable Travel	(911)	25	9
10	Non-Allowable Legal Services	(12,050)	19	10
11	Additional R&M	9,870	06	11
12	Capitalized R&M	(47,542)	06	12
13	PAC Dues	(17,593)	20	13
14	Building Company Amortization	(20,323)	31	14
15	Building Company Licenses & Permits	(1,620)	20	15
16	Building Company Professional Fees	(3,000)	19	16
17	Building Company Other Expenses	(480)	21	17
18	Building 4930 Real Estate Tax Expense	(9,403)	33	18
19	Prior Year R&M	(1,430)	06	19
20	Prior Year Medical Supplies	(44,401)	10	20
21	Prior Year Recruitment	(4,931)	20	21
22	Prior Year Expenses	(21,787)	21	22
23	Non-Allowable Accounting Fee	(5,000)	19	23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(488,252)		49

Mid America Care Center

ID# 0047035

Report Period Beginning: 01/01/14

Ending: 12/31/14

	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:** 01/01/14 **Ending:** 12/31/14

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			149									149	1
2	Food Purchase	(3,505)											(3,505)	2
3	Housekeeping			2,527									2,527	3
4	Laundry													4
5	Heat and Other Utilities	(13,069)	1,229	2,676	1,053								(8,111)	5
6	Maintenance	(39,102)	3,585	9,472	406								(25,639)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(55,676)	4,814	14,824	1,459								(34,579)	8
	B. Health Care and Programs													
9	Medical Director			14,596									14,596	9
10	Nursing and Medical Records	(44,435)		53,571									9,136	10
10a	Therapy													10a
11	Activities			27									27	11
12	Social Services			9,911									9,911	12
13	CNA Training													13
14	Program Transportation							(2,292)					(2,292)	14
15	Other (specify):*			9,802									9,802	15
16	**TOTAL Health Care and Programs**	(44,435)		87,907				(2,292)					41,180	16
	C. General Administration													
17	Administrative			215,537		129,740	(411,390)						(66,113)	17
18	Directors Fees													18
19	Professional Services	(20,050)	3,000	(462,003)	884	(131,148)							(609,317)	19
20	Fees, Subscriptions & Promotions	(144,245)	1,620	7,655	23								(134,947)	20
21	Clerical & General Office Expenses	(452,815)	(16,641)	216,257	78	75	411						(252,635)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			294									294	24
25	Other Admin. Staff Transportation	(911)		1,827		5,372							6,288	25
26	Insurance-Prop.Liab.Malpractice		23,726	823	477								25,026	26
27	Other (specify):*			81,426			4,687						86,113	27
28	**TOTAL General Administration**	(618,022)	11,705	61,816	1,462	4,039	(406,292)						(945,292)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(718,132)	16,519	164,547	2,921	4,039	(406,292)	(2,292)					(938,690)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mid America Care Center # 0047035 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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	(23,522)	33,600	11,500	4,754								26,332	30
31	Amortization of Pre-Op. & Org.	(24,636)	20,323										(4,313)	31
32	Interest	(287,227)	49,878	240	9,559								(227,550)	32
33	Real Estate Taxes	(9,403)	341,355		7,748								339,700	33
34	Rent-Facility & Grounds		(1,320,000)	34,132	(34,132)								(1,320,000)	34
35	Rent-Equipment & Vehicles			801									801	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(344,788)	(874,844)	46,673	(12,071)								(1,185,030)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(225,337)											(225,337)	43
44	**TOTAL Special Cost Centers**	(225,337)											(225,337)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,288,257)	(858,325)	211,220	(9,150)	4,039	(406,292)	(2,292)					(2,349,057)	45

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.		$	$ (1,320,000)	1
2	V	21	Miscellaneous Income	1	Mid America Convalescent Center, Inc.			(1)	2
3	V	32	Interest	529,623	Mid America Convalescent Center, Inc.		579,501	49,878	3
4	V	21	Prior Period Adjustment	17,120	Mid America Convalescent Center, Inc.			(17,120)	4
5	V	31	Amortization		Mid America Convalescent Center, Inc.		20,323	20,323	5
6	V	33	Real Estate Taxes		Mid America Convalescent Center, Inc.		341,355	341,355	6
7	V	20	Licenses & Permits		Mid America Convalescent Center, Inc.		1,620	1,620	7
8	V	06	Housekeeping & Plant Costs		Mid America Convalescent Center, Inc.		3,585	3,585	8
9	V	26	Multiperil Insurance		Mid America Convalescent Center, Inc.		23,726	23,726	9
10	V	19	Professional Fees		Mid America Convalescent Center, Inc.		3,000	3,000	10
11	V	05	Utilities	4,354	Mid America Convalescent Center, Inc.		5,583	1,229	11
12	V	30	Depreciation		Mid America Convalescent Center, Inc.		33,600	33,600	12
13	V	21	Other Expenses		Mid America Convalescent Center, Inc.		480	480	13
14	Total			$ 1,871,098			$ 1,012,773	$ * (858,325)	14

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

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/14 Ending: 12/31/14

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%	$ 149	$ 149	15
16	V	3	HOUSEKEEPING		MANAGCARE, INC.	100.00%	2,527	2,527	16
17	V	5	UTILITIES		MANAGCARE, INC.	100.00%	2,676	2,676	17
18	V	6	REPAIRS AND MAINT.		MANAGCARE, INC.	100.00%	9,472	9,472	18
19	V	9	MEDICAL DIRECTOR		MANAGCARE, INC.	100.00%	14,596	14,596	19
20	V	10	NURSING SALARIES/CONSULT	49,600	MANAGCARE, INC.	100.00%	103,171	53,571	20
21	V	11	ACTIVITIES		MANAGCARE, INC.	100.00%	27	27	21
22	V	12	SOCIAL SERVICE SALARIES		MANAGCARE, INC.	100.00%	9,911	9,911	22
23	V	15	NURSING EMP BENS & PR TAXES		MANAGCARE, INC.	100.00%	9,802	9,802	23
24	V	17	ADMINISTRATIVE SALARIES		MANAGCARE, INC.	100.00%	215,537	215,537	24
25	V	19	PROFESSIONAL FEES		MANAGCARE, INC.	100.00%	9,197	9,197	25
26	V	20	FEES, SUBSCRIPTIONS		MANAGCARE, INC.	100.00%	7,655	7,655	26
27	V	21	CLERICAL AND GENERAL SALARIES		MANAGCARE, INC.	100.00%	201,602	201,602	27
28	V	21	CLERICAL AND GENERAL EXP		MANAGCARE, INC.	100.00%	14,655	14,655	28
29	V	24	SEMINARS		MANAGCARE, INC.	100.00%	294	294	29
30	V	25	ADMIN. STAFF TRANS.		MANAGCARE, INC.	100.00%	1,827	1,827	30
31	V	26	INSURANCE		MANAGCARE, INC.	100.00%	823	823	31
32	V	27	GEN. ADMIN. EMP. BEN.		MANAGCARE, INC.	100.00%	81,426	81,426	32
33	V	30	DEPRECIATION		MANAGCARE, INC.	100.00%	11,500	11,500	33
34	V	32	INTEREST EXPENSE		MANAGCARE, INC.	100.00%	240	240	34
35	V	34	RENT - BUILDING (RELATED)		MANAGCARE, INC.	100.00%	34,132	34,132	35
36	V	35	EQUIPMENT RENTAL		MANAGCARE, INC.	100.00%	801	801	36
37	V	19	BOOKKEEPING	390,600	MANAGCARE, INC.	100.00%		(390,600)	37
38	V	19	ADMINISTRATIVE CONSULTANT	80,600	MANAGCARE, INC.	100.00%		(80,600)	38
39	Total			$ 520,800			$ 732,020	$ * 211,220	39

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

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/14 Ending: 12/31/14

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%	$ 1,053	$ 1,053	15
16	V	6	REPAIRS & MAINT.		4600 TOUHY, LLC	100.00%	406	406	16
17	V	19	PROFESSIONAL FEES		4600 TOUHY, LLC	100.00%	884	884	17
18	V	20	FEES, SUBSCRIPTIONS		4600 TOUHY, LLC	100.00%	23	23	18
19	V	21	CLERICAL & GENERAL		4600 TOUHY, LLC	100.00%	78	78	19
20	V	26	INSURANCE		4600 TOUHY, LLC	100.00%	477	477	20
21	V	30	DEPRECIATION		4600 TOUHY, LLC	100.00%	4,754	4,754	21
22	V	32	INTEREST EXPENSE		4600 TOUHY, LLC	100.00%	9,559	9,559	22
23	V	33	REAL ESTATE TAXES		4600 TOUHY, LLC	100.00%	7,748	7,748	23
24	V								24
25	V	34	RENT	34,132	4600 TOUHY, LLC	100.00%		(34,132)	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			$ 34,132			$ 24,982	$ * (9,150)	39

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

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/14 Ending: 12/31/14

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%	$ 39,920	$ 39,920	15
16	V	17	ADMINISTRATIVE SALARY - JOSH DAVIS		TETRAD MANAGEMENT, LLC	100.00%	39,920	39,920	16
17	V	17	ADMINISTRATIVE SALARY - MOSHE DAVIS		TETRAD MANAGEMENT, LLC	100.00%	39,920	39,920	17
18	V	19	PROFESSIONAL FEES		TETRAD MANAGEMENT, LLC	100.00%	599	599	18
19	V	21	OFFICE EXPENSE		TETRAD MANAGEMENT, LLC	100.00%	75	75	19
20	V	25	TRAVEL		TETRAD MANAGEMENT, LLC	100.00%	5,372	5,372	20
21	V	17	ADMINISTRATIVE SALARY - ELI DAVIS		TETRAD MANAGEMENT, LLC	100.00%	9,980	9,980	21
22	V								22
23	V	19	ADMINISTRATIVE CONSULTANT	131,747	TETRAD MANAGEMENT, LLC	100.00%		(131,747)	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			$ 131,747			$ 135,786	$ * 4,039	39

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

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/14 Ending: 12/31/14

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%	$ 12,839	$ 12,839	15
16	V	17	COMMISSIONS AND FEES		INTERCARE, LTD. C/O MANAGCARE	100.00%	33,895	33,895	16
17	V	21	CLERICAL & GENERAL		INTERCARE, LTD. C/O MANAGCARE	100.00%	411	411	17
18	V	27	EMPLOYEE BENEFITS		INTERCARE, LTD. C/O MANAGCARE	100.00%	4,687	4,687	18
19	V								19
20	V	17	MANAGEMENT FEES	458,124	INTERCARE, LTD. C/O MANAGCARE	100.00%		(458,124)	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			$ 458,124			$ 51,832	$ * (406,292)	39

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

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	14	Ambulance	$ 9,874	Lifeline Ambulance	100.00%	$ 7,582	$ (2,292)	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			$ 9,874			$ 7,582	$ * (2,292)	39

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

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Mid America Care Center # 0047035 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Relative	Mgmt / Admin	0.06%	See Attached	3.59	11.97%	Alloc. Salary	$ 12,839	17-7	1
2	Moshe Davis	Shareholder	Mgmt / Admin	0.59%	See Attached	8.78	19.95%	Alloc. Fees	39,920	17-7	2
3	Yehoshua Davis	Shareholder	Administrative	0.59%	See Attached	9.58	19.96%	Alloc. Fees	39,920	17-7	3
4	Nesanel Davis	Shareholder	Administrative	0.59%	See Attached	9.58	19.96%	Alloc. Fees	39,920	17-7	4
5	Eli Davis	Shareholder	Administrative	0.59%	See Attached	7.98	19.95%	Alloc. Fees	43,875	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	$ 176,474		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	487,280	10	$ 748	$	97,261	$ 149	1
2	3	HOUSEKEEPING	PATIENT DAYS	487,280	10	12,659		97,261	2,527	2
3	5	UTILITIES	PATIENT DAYS	487,280	10	13,409		97,261	2,676	3
4	6	REPAIRS AND MAINT.	PATIENT DAYS	487,280	10	47,454		97,261	9,472	4
5	9	MEDICAL DIRECTOR	PATIENT DAYS	487,280	10	73,125		97,261	14,596	5
6	10	NURSING SALARIES	PATIENT DAYS	487,280	10	516,890	516,890	97,261	103,171	6
7	11	ACTIVITIES	PATIENT DAYS	487,280	10	136		97,261	27	7
8	12	SOCIAL SERVICE SALARIES	PATIENT DAYS	487,280	10	49,654	49,654	97,261	9,911	8
9	15	NURSING EMP BENS & PR TA	PATIENT DAYS	487,280	10	49,107		97,261	9,802	9
10	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	487,280	10	1,079,846	1,079,846	97,261	215,537	10
11	19	PROFESSIONAL FEES	PATIENT DAYS	487,280	10	46,077		97,261	9,197	11
12	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	487,280	10	38,354		97,261	7,655	12
13	21	CLERICAL AND GENERAL SA	PATIENT DAYS	487,280	10	1,010,032	1,010,032	97,261	201,602	13
14	21	CLERICAL AND GENERAL EX	PATIENT DAYS	487,280	10	73,419		97,261	14,655	14
15	24	SEMINARS	PATIENT DAYS	487,280	10	1,473		97,261	294	15
16	25	ADMIN. STAFF TRANS.	PATIENT DAYS	487,280	10	9,155		97,261	1,827	16
17	26	INSURANCE	PATIENT DAYS	487,280	10	4,123		97,261	823	17
18	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	487,280	10	407,944		97,261	81,426	18
19	30	DEPRECIATION	PATIENT DAYS	487,280	10	57,614		97,261	11,500	19
20	32	INTEREST EXPENSE	PATIENT DAYS	487,280	10	1,200		97,261	240	20
21	34	RENT - BUILDING (RELATED)	PATIENT DAYS	487,280	10	171,000		97,261	34,132	21
22	35	EQUIPMENT RENTAL	PATIENT DAYS	487,280	10	4,015		97,261	801	22
23										23
24										24
25	TOTALS					$ 3,667,434	$ 2,656,422		$ 732,020	25

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	487,280	10	$ 5,277	$	97,261	$ 1,053	1
2	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS	487,280	10	2,035		97,261	406	2
3	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS	487,280	10	4,429		97,261	884	3
4	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS	487,280	10	148		97,261	23	4
5	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS	487,280	10	391		97,261	78	5
6	26	INSURANCE	MNGCR. PATIENT DAYS	487,280	10	2,388		97,261	477	6
7	30	DEPRECIATION	MNGCR. PATIENT DAYS	487,280	10	23,819		97,261	4,754	7
8	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS	487,280	10	47,891		97,261	9,559	8
9	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS	487,280	10	38,818		97,261	7,748	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					$ 125,196	$		$ 24,982	25

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	487,280	10	$ 200,000	$ 200,000	97,261	$ 39,920	1
2	17	ADMINISTRATIVE SALARY -	PATIENT DAYS	487,280	10	200,000	200,000	97,261	39,920	2
3	17	ADMINISTRATIVE SALARY -	PATIENT DAYS	487,280	10	200,000	200,000	97,261	39,920	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	487,280	10	3,000		97,261	599	4
5	21	OFFICE EXPENSE	PATIENT DAYS	487,280	10	374		97,261	75	5
6	25	TRAVEL	PATIENT DAYS	487,280	10	26,914		97,261	5,372	6
7	17	ADMINISTRATIVE SALARY -	PATIENT DAYS	487,280	10	50,000	50,000	97,261	9,980	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					$ 680,288	$ 650,000		$ 135,786	25

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	189,385	3	$ 25,000	$ 25,000	97,261	$ 12,839	1
2	17	COMMISSIONS AND FEES	AVG. HOURS WORKED	189,385	3	66,000		97,261	33,895	2
3	21	CLERICAL & GENERAL	AVG. HOURS WORKED	189,385	3	801		97,261	411	3
4	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	189,385	3	9,127		97,261	4,687	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					$ 100,928	$ 25,000		$ 51,832	25

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/14 Ending: 12/31/14

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: 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	14	Ambulance	Direct Allocation			$	$		$ 7,582	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					$	$		$ 7,582	25

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/14 Ending: 12/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	MB Financial		X	Mortgage			$	$ 14,000,000			$ 567,778	1
2	MB Financial		X	Loan Payable				5,800,000			11,723	2
3												3
4												4
5												5
	Working Capital											
6	MB Financial		X	Line of Credit				2,680,000			256,693	6
7	GMAC		X					5,018			1,444	7
8	See Supplemental Schedule										9,799	8
9	TOTAL Facility Related						$	$ 22,485,018			$ 847,437	9
	B. Non-Facility Related*											
10	Interest Income		X								(287,227)	10
11	Interest Income- Bldg. Co.		X								(529,623)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (816,850)	14
15	TOTALS (line 9+line14)						$	$ 22,485,018			$ 30,587	15

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

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

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

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Allocated from Managcare		X				$	$			$ 240	8
9	Allocated from 4600 Touhy LLC		X								9,559	9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										9,799	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: 01/01/14 Ending: 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	329,500	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.)	$	328,800	2
3. Under or (over) accrual (line 2 minus line 1).	$	(700)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)	$	340,400	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.)**	$	1,447	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 $ 4,340 For 2011 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.	$	341,147	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	275,465	8
	2010	287,457	9
	2011	286,262	10
	2012	316,765	11
	2013	321,052	12

2014Accrual = $321,052 + $5,660 (non-care bill) x 1.04 = $340,400 (rounded)

Allocation From 4600 Touhy LLC: $7,748

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 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 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-08-410-017-0000		$ 5,659.77	$
2.	14-08-410-018-0000	Long Term Care Property	$ 87,923.47	$ 87,923.47
3.	14-08-410-019-0000	Long Term Care Property	$ 87,923.47	$ 87,923.47
4.	14-08-410-020-0000	Long Term Care Property	$ 87,923.47	$ 87,923.47
5.	14-08-410-021-0000	Long Term Care Property	$ 57,281.61	$ 57,281.61
6.	04-08-410-022-0000		$ 8,184.39	$
7.	See Attached	Allocated From 4600 Touhy LLC	$ 84,567.54	$ 8,439.83
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 419,463.72	$ 329,491.85

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

IMPORTANT NOTICE

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

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

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY 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: 01/01/14 Ending: 12/31/14

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 [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	94,500	1979	$ 307,874	1
2	Allocated from 4600 Touhy			17,964	2
3	TOTALS	94,500		$ 325,838	3

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 33,600		$	$ (33,600)	$ 3,292,213	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			33,825	19
20	Various			1989	23,916		20	148	148	23,900	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			7,132	24
25	Various			1994	32,273		20	1,175	1,175	32,263	25
26	Various			1995	227,831		20	11,236	11,236	222,424	26
27	Various			1996	136,732		20	6,809	6,809	126,912	27
28	Various			1997	26,804		20	1,339	1,339	23,503	28
29	Various			1998	81,506		20	4,075	4,075	67,063	29
30	Various			1999	113,499		20	5,675	5,675	88,103	30
31	Various			2000	308,605		20	15,262	15,262	224,837	31
32	Various			2001	56,517		20	2,826	2,826	38,194	32
33	Various			2002	66,827		20	863	863	60,997	33
34	Various			2003	33,074		20	1,058	1,058	28,895	34
35	Various			2004	12,735		20	723	723	9,078	35
36	Various			2005	13,227		20	1,213	1,213	11,101	36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 1,444	$ 1,444	$ 21,295	37
38	Various	2007	118,844		20	9,738	9,738	92,871	38
39	Various	2008	127,264		20	11,198	11,198	69,086	39
40	Various	2009	381,166		20	29,839	29,839	153,503	40
41	Various	2010	73,076		20	3,654	3,654	15,027	41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		211,528	6,741		8,868	2,127	26,728	68
69	Financial Statement Depreciation			298,218			(298,218)		69
70	TOTAL (lines 4 thru 69)		$ 5,763,266	$ 338,559		$ 117,141	$ (221,418)	$ 5,043,304	70

**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: 01/01/14 Ending: 12/31/14

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		$ 5,763,266	$ 338,559		$ 117,141	$ (221,418)	$ 5,043,304	1
2	Epoxy Quartz Flooring	2011	22,000		20	1,467	1,467	5,622	2
3	Aluminum Double Hung Windows	2011	191,328		20	19,133	19,133	68,559	3
4	Custom Shaped Canopy	2011	6,080		20	1,216	1,216	4,256	4
5	Fire Rated Access Doors	2011	3,527		20	353	353	1,205	5
6	Custom Sign	2011	5,651		20	565	565	1,884	6
7	Elevator Wraps	2011	7,608		20	380	380	1,458	7
8	Galvanized Piping	2011	8,750		20	875	875	3,427	8
9	Kitchen Dish Room Flooring	2012	4,900		20	245	245	510	9
10	Furnish And Install Footing, Steel And Concrete Slab	2012	7,500		20	375	375	781	10
11	Install Emergency Generator	2012	221,840		20	11,092	11,092	23,108	11
12	Repair Water Chiller	2012	5,944		20	297	297	619	12
13	4Th Fl Dayroom- Wallcovering, Painting, Window Treatments	2012	6,784		20	339	339	707	13
14	4Th Floordayroom: Wallcoverings,Handrails,Bump.Guards,Windo	2012	162,781		20	8,139	8,139	16,956	14
15	Roof Patching And Wall Flashing	2012	3,200		20	160	160	333	15
16	Asphalt Surface Sealing	2012	3,170		20	159	159	330	16
17	Med Room Doors On All 5 Floors	2013	7,767		20	777	777	1,553	17
18	Fire Alarm System	2013	3,133		20	313	313	627	18
19	5 Metal Door Frames On 2Nd, 3Rd, 4Th, 5Th, 6Th Floors	2013	6,100		20	610	610	1,169	19
20	2Nd Floor Bed Outlets	2013	13,500		20	1,350	1,350	2,363	20
21	Stairway Handrail	2013	7,250		20	725	725	1,450	21
22	Chiller Repair	2013	6,522		20	544	544	815	22
23	Drain Piping Repair From North & South Walls	2013	3,460		20	346	346	461	23
24	Door For 6Th Floor Oxygen Room	2013	2,609		20	130	130	250	24
25	2 Space Heaters	2014	6,900		20	259	259	259	25
26	Cable & Alarm System Work	2014	3,691		20	185	185	185	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,485,261	$ 338,559		$ 167,174	$ (171,385)	$ 5,182,193	34

**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: 01/01/14 Ending: 12/31/14

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		$ 6,485,261	$ 338,559		$ 167,174	$ (171,385)	$ 5,182,193	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,485,261	$ 338,559		$ 167,174	$ (171,385)	$ 5,182,193	34

**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: 01/01/14 Ending: 12/31/14

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		$ 6,485,261	$ 338,559		$ 167,174	$ (171,385)	$ 5,182,193	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,485,261	$ 338,559		$ 167,174	$ (171,385)	$ 5,182,193	34

**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: 01/01/14 Ending: 12/31/14

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		$ 6,485,261	$ 338,559		$ 167,174	$ (171,385)	$ 5,182,193	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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20									20
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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)		$ 6,485,261	$ 338,559		$ 167,174	$ (171,385)	$ 5,182,193	34

**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: 01/01/14 Ending: 12/31/14

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 12E, Carried Forward		$	$		$	$	$	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	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

**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: 01/01/14 Ending: 12/31/14

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 12F, Carried Forward		$	$		$	$	$	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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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)		$	$		$	$	$	34

**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: 01/01/14 Ending: 12/31/14

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 12G, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from 4600 Touhy LLC	2012	102,486	2,628	30	3,416	788	10,249	3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated from Managcare	2013	1,721	458	20	86	(372)	172	9
10	Allocated from Managcare	2012	21,397	1,529	20	1,070	(459)	3,210	10
11									11
12	Allocated from 4600 Touhy LLC	2012	66,001	1,710	20	3,300	1,590	9,900	12
13	Allocated from 4600 Touhy LLC	2013	16,060	377	20	803	426	1,606	13
14	Allocated from 4600 Touhy LLC	2014	1,596	39	20	80	41	80	14
15									15
16	Allocated from Inter Care Ltd	2001	2,267		20	113	113	1,511	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 211,528	$ 6,741		$ 8,868	$ 2,127	$ 26,728	34

**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: 01/01/14 Ending: 12/31/14

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 12H, Carried Forward		$ 211,528	$ 6,741		$ 8,868	$ 2,127	$ 26,728	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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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 211,528	$ 6,741		$ 8,868	$ 2,127	$ 26,728	34

**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: 01/01/14 Ending: 12/31/14

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	$ 1,166,630	$ 8,344	$ 141,606	$ 133,262	10	$ 698,572	71
72	Current Year Purchases	89,699		9,282	9,282	10	9,282	72
73	Fully Depreciated Assets	1,135,836				10	1,135,836	73
74								74
75	TOTALS	$ 2,392,165	$ 8,344	$ 150,889	$ 142,545		$ 1,843,690	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	$ 20,632	76
77		Allocated from Managcare	2014	24,123		2,738	2,738	5	22,058	77
78										78
79					1,169		(1,169)			79
80	TOTALS			$ 46,630	$ 1,169	$ 6,488	$ 5,319		$ 42,690	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)	$ 9,249,894	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 348,072	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 324,551	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (23,522)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,068,573	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	C-I-P	$ 159,241	92
93	C-I-P - Building Company	51,231	93
94			94
95		$ 210,472	95

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

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

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 801 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	$	$ 4,543	17
18					18
19					19
20					20
21	TOTAL		$	$ 4,543	21

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

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

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

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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	$		$ 424,951	$		$ 424,951	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			143,538			143,538	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			501,912			501,912	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				238,539		238,539	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					81,835	29,263		111,098	13
14	TOTAL			$		$ 1,152,236	$ 267,802		$ 1,420,038	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.

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (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	$ 418,229	$ 1,081,465	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,689,597	5,744,597	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	214,304	226,218	6
7	Other Prepaid Expenses	74,136	74,136	7
8	Accounts Receivable (owners or related parties)	4,872,253	22,199,781	8
9	Other(specify):	4,796,918	5,000,875	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 15,065,437	$ 34,327,072	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	1,647,776	3,133,513	15
16	Equipment, at Historical Cost	1,103,387	2,363,406	16
17	Accumulated Depreciation (book methods)	(1,436,229)	(6,947,415)	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):	223,588	591,724	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,538,522	$ 2,884,250	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 16,603,959	$ 37,211,322	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,107,141	$ 2,105,815	26
27	Officer's Accounts Payable	35,371	35,371	27
28	Accounts Payable-Patient Deposits	50,942	50,942	28
29	Short-Term Notes Payable	2,685,018	2,685,018	29
30	Accrued Salaries Payable	473,494	473,494	30
31	Accrued Taxes Payable (excluding real estate taxes)	34,533	34,533	31
32	Accrued Real Estate Taxes(Sch.IX-B)		340,400	32
33	Accrued Interest Payable	22,813	49,257	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	7,145,348	7,318,437	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 12,554,660	$ 13,093,267	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		5,800,000	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)**	$	$ 19,800,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 12,554,660	$ 32,893,267	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,049,299	$ 4,318,055	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 16,603,959	$ 37,211,322	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,365,877	1
2	Restatements (describe):		2
3	**State Replacement Tax**	(31,100)	3
4	**Rounding**	9	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,334,786	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,340,738	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	(626,225)	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)**	$ 714,513	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 4,049,299	24 *

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

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 18,958,882	1
2	Discounts and Allowances for all Levels	(4,398,481)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 14,560,401	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,586,865	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,586,865	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	276,496	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	28,083	19
20	Radiology and X-Ray	4,140	20
21	Other Medical Services	29,645	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 338,364	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	287,227	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 287,227	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	42,079	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 42,079	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 17,814,936	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,580,240	31
32	Health Care	5,419,295	32
33	General Administration	4,217,150	33
	B. Capital Expense		
34	Ownership	1,885,211	34
	C. Ancillary Expense		
35	Special Cost Centers	1,645,375	35
36	Provider Participation Fee	726,927	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 16,474,198	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,340,738	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,340,738	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 12,778,590	44
45	Private Pay - Net Inpatient Revenue	307,386	45
46	Medicare - Net Inpatient Revenue	1,150,788	46
47	Other-(specify) Hospice	182,388	47
48	Other-(specify) Insurance	141,249	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 14,560,401	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.**

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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	1,882	2,080	$ 107,739	$ 51.80	1
2	Assistant Director of Nursing	3,416	3,989	158,272	39.68	2
3	Registered Nurses	41,093	43,939	1,308,143	29.77	3
4	Licensed Practical Nurses	32,710	36,399	907,679	24.94	4
5	CNAs & Orderlies	117,044	129,838	1,481,383	11.41	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,358	6,129	144,862	23.64	8
9	Activity Director	1,865	2,013	37,475	18.62	9
10	Activity Assistants	14,726	16,541	167,374	10.12	10
11	Social Service Workers	14,383	16,157	279,692	17.31	11
12	Dietician					12
13	Food Service Supervisor	8,695	9,630	164,313	17.06	13
14	Head Cook					14
15	Cook Helpers/Assistants	26,681	29,218	297,019	10.17	15
16	Dishwashers					16
17	Maintenance Workers	5,296	6,152	128,872	20.95	17
18	Housekeepers	38,992	43,739	470,383	10.75	18
19	Laundry	18,525	20,558	215,910	10.50	19
20	Administrator					20
21	Assistant Administrator	2,000	2,240	107,167	47.84	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	26,044	28,590	478,199	16.73	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,211	4,773	69,783	14.62	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	3,440	3,872	167,937	43.37	33
34	TOTAL (lines 1 - 33)	366,361	405,857	$ 6,692,202 *	$ 16.49	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	583	$ 26,858	01-03	35
36	Medical Director	Monthly	66,120	09-03	36
37	Medical Records Consultant	Monthly	1,176	10-03	37
38	Nurse Consultant	Monthly	80,450	10-03	38
39	Pharmacist Consultant	Monthly	17,465	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	55	3,039	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	15	1,525	11-03	44
45	Social Service Consultant	393	18,640	12-03	45
46	Other(specify)				46
47	Renal Therapy Consult	Monthly	157,390	10a-03	47
48	MDS Consult	Monthly	55,684	10-03	48
49	TOTAL (lines 35 - 48)	1,046	$ 428,347		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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michael Applebaum	Asst. Admin.	0	$ 107,167
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 107,167

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	$ 195,029
Frost, Ruttenberg & Rothblatt	Accounting	21,240
Personnel Planners	Unemployment Consult	6,794
Managcare Inc.	Bookkeeping	390,600
Achieve Accreditation	Insurance Consultant	23,656
Managcare Inc.	Administrative Consult	80,600
Tetrad Management	Administrative Consult	131,747
Provinet Solutions	IT Consulting	10,821
Legat Architects	Architectural Consulting	8,280
ADAR	Cloud Based IT Solutions	11,805
Health Medx LLC	EMR Software	58,844
See Supplemental Schedule		11,929
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 951,345

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 90,161
Unemployment Compensation Insurance	42,859
FICA Taxes	499,106
Employee Health Insurance	320,899
Employee Meals	49,604
Illinois Municipal Retirement Fund (IMRF)*	
Dental Insurance	870
Life Insurance	2,373
Other Employee Benefits	25,725
Pension Expense	43,142
Safe Harbor Match Expense	64,648
Disability Insurance	4,344
See Supplemental Schedule	9,005
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,152,734

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	29,771
Health Care Worker Background Check	
(Indicate # of checks performed 35)	1,264
Patient Background Checks 244	4,917
Licenses & Permits	3,938
Dues & Subscriptions	22,774
Allocated from Managcare	7,655
Allocated from 4600 Touhy LLC	23
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 70,342

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,407
Allocated from Managcare	294
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,701

* Attach copy of IMRF notifications

**See instructions.

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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													
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16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Mid America Care Center # 0047035 Report Period Beginning: 01/01/14 Ending: 12/31/14

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- $30,039**

(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. $ **40,162** 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. $ **726,927**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **49,604** 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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.