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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0047035

Facility Name: Mid America Care Center, Llc

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) 282-6300
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 01/01/15 to 12/31/15 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)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	51,770	1,289	8,319	61,378	8
9	SNF/PED					9
10	ICF	32,550			32,550	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	84,320	1,289	8,319	93,928	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.01%

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 5,245

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: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number Mid America Care Center, Llc # 0047035 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	464,975	170,899	29,117	664,991		664,991	111	665,102			1
2	Food Purchase		480,600		480,600	(49,604)	430,997	(3,221)	427,775			2
3	Housekeeping	306,840	56,892	158,178	521,910		521,910	2,193	524,103			3
4	Laundry	211,274	14,605		225,879		225,879		225,879			4
5	Heat and Other Utilities			288,601	288,601		288,601	(3,187)	285,414			5
6	Maintenance	177,184	33,462	107,828	318,474		318,474	25,496	343,970			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,160,273	756,458	583,724	2,500,455	(49,604)	2,450,852	21,393	2,472,244			8
	B. Health Care and Programs											
9	Medical Director			51,120	51,120		51,120	601	51,721			9
10	Nursing and Medical Records	4,015,086	206,412	136,088	4,357,586		4,357,586	75,399	4,432,985			10
10a	Therapy	142,208		140,192	282,400		282,400	10,270	292,670			10a
11	Activities	188,168	11,809		199,977		199,977	18	199,995			11
12	Social Services	292,201		18,600	310,801		310,801	10,769	321,570			12
13	CNA Training											13
14	Program Transportation			5,419	5,419		5,419	(169)	5,250			14
15	Other (specify):*							17,500	17,500			15
16	**TOTAL Health Care and Programs**	4,637,663	218,221	351,419	5,207,303		5,207,303	114,388	5,321,691			16
	C. General Administration											
17	Administrative	103,824		458,124	561,948		561,948	(356,659)	205,289			17
18	Directors Fees											18
19	Professional Services			1,169,268	1,169,268	(18,599)	1,150,669	(1,016,910)	133,759			19
20	Dues, Fees, Subscriptions & Promotions			203,540	203,540		203,540	(126,866)	76,674			20
21	Clerical & General Office Expenses	365,383	27,657	991,803	1,384,843		1,384,843	(576,588)	808,255			21
22	Employee Benefits & Payroll Taxes			1,027,947	1,027,947	49,604	1,077,551	(5,060)	1,072,491			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,089	3,089		3,089	106	3,195			24
25	Other Admin. Staff Transportation			8,691	8,691		8,691	1,634	10,325			25
26	Insurance-Prop.Liab.Malpractice			474,229	474,229		474,229	13,119	487,348			26
27	Other (specify):*							100,290	100,290			27
28	**TOTAL General Administration**	469,207	27,657	4,336,691	4,833,555	31,004	4,864,559	(1,966,934)	2,897,626			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,267,143	1,002,336	5,271,834	12,541,313	(18,599)	12,522,714	(1,831,153)	10,691,561			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, Llc #0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			290,092	290,092		290,092	33,470	323,562			30
31	Amortization of Pre-Op. & Org.			4,313	4,313		4,313	(4,313)				31
32	Interest			311,746	311,746		311,746	(59,534)	252,212			32
33	Real Estate Taxes			30,994	30,994	18,599	49,593	325,480	375,073			33
34	Rent-Facility & Grounds			1,476,000	1,476,000		1,476,000	(1,476,000)	0			34
35	Rent-Equipment & Vehicles			5,363	5,363		5,363	1,311	6,674			35
36	Other (specify):*											36
37	TOTAL Ownership			2,118,508	2,118,508	18,599	2,137,107	(1,179,587)	957,521			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		349,649	1,107,085	1,456,734		1,456,734		1,456,734			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			700,729	700,729		700,729		700,729			42
43	Other (specify):*	206,405		55,800	262,205		262,205	(262,205)				43
44	TOTAL Special Cost Centers	206,405	349,649	1,863,614	2,419,668		2,419,668	(262,205)	2,157,463			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,473,548	1,351,985	9,253,956	17,079,489		17,079,489	(3,272,944)	13,806,545			45

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

Facility Name & ID Number Mid America Care Center, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(13,753)	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	(17,604)	30		9
10	Interest and Other Investment Income	(279,563)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(65)	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				18
19	Entertainment				19
20	Contributions	(94,070)	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	(686,532)	21		24
25	Fund Raising, Advertising and Promotional	(42,102)	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	(516,829)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,650,518)		$	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)	(1,622,427)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,622,427)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (3,272,944)		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

Mid America Care Center, Llc

ID# 0047035

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (3,156)	02	1
2	Misc. Income	(83,605)	21	2
3	Marketing Consultant	(55,800)	43	3
4	Bank Charges	(4,397)	21	4
5	Marketing Salaries	(206,405)	43	5
6	Theft & Loss	(503)	21	6
7	Sequestration Expense	(59,997)	21	7
8	Amortization	(4,313)	31	8
9	Capitalized R&M	(3,098)	06	9
10	Prior Period Expense	(5,060)	22	10
11	Jury Duty	(94)	10	11
12	Additional R&M	4,656	06	12
13	Non-Allowable Legal	(48,490)	19	13
14	Marketing Travel	(4,262)	25	14
15	Non-Allowable Interest Expense	(758)	32	15
16	Building Company Amortization	(24,406)	31	16
17	Building Company Due & Subscriptions	(205)	20	17
18	Building Company Professional Fees	(7,311)	19	18
19	Building Company Replacement Tax	(1,513)	21	19
20	Building 4930 Real Estate Tax Expense	(3,113)	33	20
21	Non-Allowable Accounting Fee	(5,000)	19	21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(516,829)		49

Mid America Care Center, Llc

ID# 0047035

Report Period Beginning: 01/01/15

Ending: 12/31/15

	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			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mid America Care Center, Llc # 0047035 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary			111									111	1
2	Food Purchase	(3,221)											(3,221)	2
3	Housekeeping			2,173	20								2,193	3
4	Laundry													4
5	Heat and Other Utilities	(13,753)	6,025	3,859	682								(3,187)	5
6	Maintenance	1,558	270	22,677	991								25,496	6
7	Other (specify):*													7
8	**TOTAL General Services**	(15,416)	6,295	28,820	1,693								21,393	8
	B. Health Care and Programs													
9	Medical Director			601									601	9
10	Nursing and Medical Records	(94)		75,493									75,399	10
10a	Therapy						10,270						10,270	10a
11	Activities			18									18	11
12	Social Services			10,769									10,769	12
13	CNA Training													13
14	Program Transportation							(169)					(169)	14
15	Other (specify):*			17,500									17,500	15
16	**TOTAL Health Care and Programs**	(94)		104,381			10,270	(169)					114,388	16
	C. General Administration													
17	Administrative			53,355			(410,014)						(356,659)	17
18	Directors Fees													18
19	Professional Services	(60,801)	7,311	(726,606)	239	(137,053)	(100,000)						(1,016,910)	19
20	Fees, Subscriptions & Promotions	(136,377)	205	9,294	12								(126,866)	20
21	Clerical & General Office Expenses	(836,546)	1,513	258,312	133								(576,588)	21
22	Employee Benefits & Payroll Taxes	(5,060)											(5,060)	22
23	Inservice Training & Education													23
24	Travel and Seminar			106									106	24
25	Other Admin. Staff Transportation	(4,262)		823		5,073							1,634	25
26	Insurance-Prop.Liab.Malpractice		11,914	758	446								13,119	26
27	Other (specify):*			99,280			1,010						100,290	27
28	**TOTAL General Administration**	(1,043,046)	20,943	(304,677)	830	(131,980)	(509,004)						(1,966,934)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,058,556)	27,238	(171,475)	2,524	(131,980)	(498,734)	(169)					(1,831,153)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mid America Care Center, Llc # 0047035 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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	(17,604)	33,439	13,093	4,542								33,470	30
31	Amortization of Pre-Op. & Org.	(28,719)	24,406										(4,313)	31
32	Interest	(280,321)	211,732		9,054								(59,534)	32
33	Real Estate Taxes	(3,113)	320,102		8,490								325,480	33
34	Rent-Facility & Grounds		(1,476,000)	19,233	(19,233)								(1,476,000)	34
35	Rent-Equipment & Vehicles			1,311									1,311	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(329,757)	(886,321)	33,638	2,853								(1,179,587)	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):*	(262,205)											(262,205)	43
44	**TOTAL Special Cost Centers**	(262,205)											(262,205)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,650,518)	(859,083)	(137,838)	5,377	(131,980)	(498,734)	(169)					(3,272,944)	45

Facility Name & ID Number Mid America Care Center, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 1,476,000	Mid America Convalescent Center, Inc.	100.00%	$	$ (1,476,000)	1
2	V	21	Miscellaneous Income		Mid America Convalescent Center, Inc.	100.00%			2
3	V	32	Interest	360,333	Mid America Convalescent Center, Inc.	100.00%	572,065	211,732	3
4	V	21	Replacement Tax		Mid America Convalescent Center, Inc.	100.00%	1,513	1,513	4
5	V	31	Amortization		Mid America Convalescent Center, Inc.	100.00%	24,406	24,406	5
6	V	33	Real Estate Taxes		Mid America Convalescent Center, Inc.	100.00%	320,102	320,102	6
7	V	20	Dues & Subscriptions		Mid America Convalescent Center, Inc.	100.00%	205	205	7
8	V	06	Housekeeping & Plant Costs		Mid America Convalescent Center, Inc.	100.00%	270	270	8
9	V	26	Insurance Expense		Mid America Convalescent Center, Inc.	100.00%	11,914	11,914	9
10	V	19	Professional Fees		Mid America Convalescent Center, Inc.	100.00%	7,311	7,311	10
11	V	05	Utilities		Mid America Convalescent Center, Inc.	100.00%	6,025	6,025	11
12	V	30	Depreciation		Mid America Convalescent Center, Inc.	100.00%	33,439	33,439	12
13	V								13
14	Total			$ 1,836,333			$ 977,250	$ * (859,083)	14

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

Facility Name & ID Number Mid America Care Center, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$	MOSAIC HEALTHCARE	100.00%	$ 111	$ 111	15
16	V	3	HOUSEKEEPING		MOSAIC HEALTHCARE	100.00%	2,173	2,173	16
17	V	5	UTILITIES		MOSAIC HEALTHCARE	100.00%	3,859	3,859	17
18	V	6	REPAIRS AND MAINT.		MOSAIC HEALTHCARE	100.00%	22,677	22,677	18
19	V	9	MEDICAL DIRECTOR		MOSAIC HEALTHCARE	100.00%	601	601	19
20	V	10	NURSING SALARIES	37,200	MOSAIC HEALTHCARE	100.00%	112,693	75,493	20
21	V	11	ACTIVITIES		MOSAIC HEALTHCARE	100.00%	18	18	21
22	V	12	SOCIAL SERVICE SALARIES		MOSAIC HEALTHCARE	100.00%	10,769	10,769	22
23	V	15	NURSING EMP BENS & PR TAXES		MOSAIC HEALTHCARE	100.00%	17,500	17,500	23
24	V	17	ADMINISTRATIVE SALARIES		MOSAIC HEALTHCARE	100.00%	53,355	53,355	24
25	V	19	PROFESSIONAL FEES		MOSAIC HEALTHCARE	100.00%	(6,216)	(6,216)	25
26	V	20	FEES, SUBSCRIPTIONS		MOSAIC HEALTHCARE	100.00%	9,294	9,294	26
27	V	21	CLERICAL AND GENERAL SALARIES		MOSAIC HEALTHCARE	100.00%	351,046	351,046	27
28	V	21	CLERICAL AND GENERAL EXP	130,200	MOSAIC HEALTHCARE	100.00%	37,465	(92,735)	28
29	V	24	SEMINARS		MOSAIC HEALTHCARE	100.00%	106	106	29
30	V	25	ADMIN. STAFF TRANS.		MOSAIC HEALTHCARE	100.00%	823	823	30
31	V	26	INSURANCE		MOSAIC HEALTHCARE	100.00%	758	758	31
32	V	27	GEN. ADMIN. EMP. BEN.		MOSAIC HEALTHCARE	100.00%	99,280	99,280	32
33	V	30	DEPRECIATION		MOSAIC HEALTHCARE	100.00%	13,093	13,093	33
34	V	32	INTEREST EXPENSE		MOSAIC HEALTHCARE	100.00%			34
35	V	34	RENT - BUILDING (RELATED)		MOSAIC HEALTHCARE	100.00%	19,233	19,233	35
36	V	35	EQUIPMENT RENTAL		MOSAIC HEALTHCARE	100.00%	1,311	1,311	36
37	V	19	BOOKKEEPING	390,600	MOSAIC HEALTHCARE	100.00%		(390,600)	37
38	V	19	ADMINISTRATIVE CONSULTANT	329,790	MOSAIC HEALTHCARE	100.00%		(329,790)	38
39	Total			$ 887,790			$ 749,952	$ * (137,838)	39

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

Facility Name & ID Number Mid America Care Center, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSKEEPING	$	4600 TOUHY, LLC	100.00%	$ 20	$ 20	15
16	V	5	UTILITIES		4600 TOUHY, LLC	100.00%	682	682	16
17	V	6	REPAIRS & MAINT.		4600 TOUHY, LLC	100.00%	991	991	17
18	V	19	PROFESSIONAL FEES		4600 TOUHY, LLC	100.00%	239	239	18
19	V	20	FEES, SUBSCRIPTIONS		4600 TOUHY, LLC	100.00%	12	12	19
20	V	21	CLERICAL & GENERAL		4600 TOUHY, LLC	100.00%	133	133	20
21	V	26	INSURANCE		4600 TOUHY, LLC	100.00%	446	446	21
22	V	30	DEPRECIATION		4600 TOUHY, LLC	100.00%	4,542	4,542	22
23	V	32	INTEREST EXPENSE		4600 TOUHY, LLC	100.00%	9,054	9,054	23
24	V	33	REAL ESTATE TAXES		4600 TOUHY, LLC	100.00%	8,490	8,490	24
25	V								25
26	V	34	RENT	19,233	4600 TOUHY, LLC	100.00%		(19,233)	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			$ 19,233			$ 24,610	$ * 5,377	39

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

Facility Name & ID Number Mid America Care Center, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	19	PROFESSIONAL FEES		TETRAD MANAGEMENT, LLC	100.00%	894	$ 894	15
16	V	25	TRAVEL		TETRAD MANAGEMENT, LLC	100.00%	5,073	5,073	16
17	V								17
18	V	19	ADMINISTRATIVE CONSULTANT	137,947	TETRAD MANAGEMENT, LLC	100.00%		(137,947)	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			$ 137,947			$ 5,967	$ * (131,980)	39

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

Facility Name & ID Number Mid America Care Center, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

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%	$ 12,464	$ 12,464	15
16	V	17	COMMISSIONS AND FEES		INTERCARE, LTD. C/O MANAGCARE	100.00%	35,646	35,646	16
17	V	10A	THERAPY CONSULTATION		INTERCARE, LTD. C/O MANAGCARE	100.00%	10,270	10,270	17
18	V	27	EMPLOYEE BENEFITS		INTERCARE, LTD. C/O MANAGCARE	100.00%	1,010	1,010	18
19	V								19
20	V	17	MANAGEMENT FEES	458,124	INTERCARE, LTD. C/O MANAGCARE	100.00%		(458,124)	20
21	V	19	ADMINISTRATIVE CONSULTING	100,000	INTERCARE, LTD. C/O MANAGCARE			(100,000)	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			$ 558,124			$ 59,390	$ * (498,734)	39

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

Facility Name & ID Number Mid America Care Center, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 2,216	Lifeline Ambulance	100.00%	$ 2,047	$ (169)	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			$ 2,216			$ 2,047	$ * (169)	39

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

Facility Name & ID Number Mid America Care Center, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

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, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

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, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

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, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

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, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	MOSAIC HEALTHCARE		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, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

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, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Yosef Davis	Shareholder	Mgmt / Admin	0.06%	See Attached	3.44	11.47%	Alloc. Salary	$ 12,464	17-7	1
2	Eli Davis	Shareholder	Administrative	0.59%	See Attached	7.64	19.10%	Alloc. Fees	35,646	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 48,110		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, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

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, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

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: MOSAIC HEALTHCARE
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	491,775	10	$ 583	$	93,928	$ 111	1
2	3	HOUSEKEEPING	PATIENT DAYS	491,775	10	11,376		93,928	2,173	2
3	5	UTILITIES	PATIENT DAYS	491,775	10	20,206		93,928	3,859	3
4	6	REPAIRS AND MAINT.	PATIENT DAYS	491,775	10	118,728		93,928	22,677	4
5	9	MEDICAL DIRECTOR	PATIENT DAYS	491,775	10	3,145		93,928	601	5
6	10	NURSING SALARIES	PATIENT DAYS	491,775	10	590,024	590,024	93,928	112,693	6
7	11	ACTIVITIES	PATIENT DAYS	491,775	10	95		93,928	18	7
8	12	SOCIAL SERVICE SALARIES	PATIENT DAYS	491,775	10	56,383	56,383	93,928	10,769	8
9	15	NURSING EMP BENS & PR TAX	PATIENT DAYS	491,775	10	91,625		93,928	17,500	9
10	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	491,775	10	279,351	279,351	93,928	53,355	10
11	19	PROFESSIONAL FEES	PATIENT DAYS	491,775	10	(32,545)		93,928	(6,216)	11
12	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	491,775	10	48,662		93,928	9,294	12
13	21	CLERICAL AND GENERAL SAI	PATIENT DAYS	491,775	10	1,837,959	1,837,959	93,928	351,046	13
14	21	CLERICAL AND GENERAL EX	PATIENT DAYS	491,775	10	196,155		93,928	37,465	14
15	24	SEMINARS	PATIENT DAYS	491,775	10	556		93,928	106	15
16	25	ADMIN. STAFF TRANS.	PATIENT DAYS	491,775	10	4,308		93,928	823	16
17	26	INSURANCE	PATIENT DAYS	491,775	10	3,971		93,928	758	17
18	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	491,775	10	519,798		93,928	99,280	18
19	30	DEPRECIATION	PATIENT DAYS	491,775	10	68,552		93,928	13,093	19
20	32	INTEREST EXPENSE	PATIENT DAYS	491,775	10			93,928		20
21	34	RENT - BUILDING (RELATED)	PATIENT DAYS	491,775	10	100,700		93,928	19,233	21
22	35	EQUIPMENT RENTAL	PATIENT DAYS	491,775	10	6,863		93,928	1,311	22
23										23
24										24
25	TOTALS					$ 3,926,495	$ 2,763,717		$ 749,952	25

Facility Name & ID Number Mid America Care Center, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	3	HOUSKEEPING	MNGCR. PATIENT DAYS	491,775	10	$ 107	$	93,928	$ 20	1
2	5	UTILITIES	MNGCR. PATIENT DAYS	491,775	10	3,569		93,928	682	2
3	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS	491,775	10	5,190		93,928	991	3
4	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS	491,775	10	1,250		93,928	239	4
5	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS	491,775	10	63		93,928	12	5
6	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS	491,775	10	698		93,928	133	6
7	26	INSURANCE	MNGCR. PATIENT DAYS	491,775	10	2,336		93,928	446	7
8	30	DEPRECIATION	MNGCR. PATIENT DAYS	491,775	10	23,779		93,928	4,542	8
9	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS	491,775	10	47,406		93,928	9,054	9
10	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS	491,775	10	44,453		93,928	8,490	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 128,850	$		$ 24,610	25

Facility Name & ID Number Mid America Care Center, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	19	PROFESSIONAL FEES	PATIENT DAYS	491,775	10	4,682		93,928	894	1
2	25	TRAVEL	PATIENT DAYS	491,775	10	26,559		93,928	5,073	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					$ 31,241	$		$ 5,967	25

Facility Name & ID Number Mid America Care Center, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	188,403	3	$ 25,000	$ 25,000	93,928	$ 12,464	1
2	17	COMMISSIONS AND FEES	AVG. HOURS WORKED	188,403	3	71,500		93,928	35,646	2
3	10A	THERAPY CONSULTATION	AVG. HOURS WORKED	188,403	3	20,600		93,928	10,270	3
4	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	188,403	3	2,026		93,928	1,010	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					$ 119,126	$ 25,000		$ 59,390	25

Facility Name & ID Number Mid America Care Center, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	14	Ambulance	Direct Allocation			$	$		$ 2,047	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					$	$		$ 2,047	25

Facility Name & ID Number Mid America Care Center, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

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, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

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, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

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, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

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, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			$ 572,065	1
2	MB Financial		X	Loan Payable				5,800,000				2
3												3
4												4
5												5
	Working Capital											
6	MB Financial		X	Line of Credit				1,075,000			310,988	6
7	GMAC		X					5,018				7
8	See Supplemental Schedule										9,054	8
9	TOTAL Facility Related						$	$ 20,880,018			$ 892,107	9
	B. Non-Facility Related*											
10	Interest Income		X								(279,563)	10
11	Interest Income- Bldg. Co.		X								(360,333)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (639,896)	14
15	TOTALS (line 9+line14)						$	$ 20,880,018			$ 252,211	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, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Allocated from 4600 Touhy LLC		X				$	$			$ 9,054	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										9,054	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, Llc **#** 0047035 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 340,400	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 346,016	2
3. Under or (over) accrual (line 2 minus line 1).		$ 5,616	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 350,857	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.**		$ 18,599	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** $ 46,844 **For** 2011 and 2012 **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.		$ 375,073	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	287,457	8
	2011	286,262	9
	2012	316,765	10
	2013	321,052	11
	2014	337,526	12

2015Accrual = $337,526 x 1.04 = $350,857

Allocation From 4600 Touhy LLC: $8,490

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mid America Care Center, Llc 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 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-08-410-018-0000	Long Term Care Property	$ 92,435.03	$ 92,435.03
2.	14-08-410-019-0000	Long Term Care Property	$ 92,435.03	$ 92,435.03
3.	14-08-410-020-0000	Long Term Care Property	$ 92,435.03	$ 92,435.03
4.	14-08-410-021-0000	Long Term Care Property	$ 60,220.85	$ 60,220.85
5.	See Attached	Allocated From 4600 Touhy LLC	$ 86,316.15	$ 8,243.10
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 423,842.09	$ 345,769.04

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? 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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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, Llc 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, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			17,190	2
3	TOTALS	94,500		$ 325,064	3

Facility Name & ID Number Mid America Care Center, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 33,439		$	$ (33,439)	$ 3,258,613	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1978	2,575		20			2,575	9
10	Various			1979	33,995		20			33,995	10
11	Various			1980	13,673		20			13,673	11
12	Various			1981	107,932		20			107,932	12
13	Various			1982	4,750		20			4,750	13
14	Various			1983	1,787		20			1,787	14
15	Various			1984	25,291		20			25,291	15
16	Various			1985	17,828		20			17,828	16
17	Various			1986	62,698		20			62,698	17
18	Various			1987	18,422		20			18,422	18
19	Various			1988	33,825		20			33,825	19
20	Various			1989	23,916		20			23,916	20
21	Various			1990	23,550		20			23,550	21
22	Various			1991	20,020		20			20,020	22
23	Various			1992	51,260		20			51,260	23
24	Various			1993	7,134		20			7,134	24
25	Various			1994	32,273		20			32,273	25
26	Various			1995	227,831		20	4,422	4,422	226,846	26
27	Various			1996	136,732		20	6,806	6,806	133,717	27
28	Various			1997	26,804		20	1,196	1,196	24,699	28
29	Various			1998	81,506		20	4,075	4,075	71,138	29
30	Various			1999	113,499		20	5,675	5,675	93,778	30
31	Various			2000	308,605		20	15,262	15,262	240,098	31
32	Various			2001	56,517		20	2,826	2,826	41,020	32
33	Various			2002	66,827		20	863	863	61,860	33
34	Various			2003	33,074		20	550	550	29,445	34
35	Various			2004	12,735		20	385	385	9,463	35
36	Various			2005	13,227		20	1,063	1,063	12,164	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, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 22,739	37
38	Various	2007	118,844		20	9,164	9,164	102,035	38
39	Various	2008	127,264		20	11,198	11,198	80,284	39
40	Various	2009	381,166		20	29,839	29,839	183,342	40
41	Various	2010	73,076		20	3,654	3,654	18,681	41
42	Various	2011	244,943		20	23,989	23,989	110,400	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)		202,442	5,759		8,487	2,728	34,194	68
69	Financial Statement Depreciation			290,092			(290,092)		69
70	TOTAL (lines 4 thru 69)		$ 5,999,123	$ 329,290		$ 130,896	$ (198,394)	$ 5,235,446	70

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

Facility Name & ID Number Mid America Care Center, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 5,999,123	$ 329,290		$ 130,896	$ (198,394)	$ 5,235,446	1
2	Kitchen Dish Room Flooring	2012	4,900		20	245	245	755	2
3	Furnish And Install Footing, Steel And Concrete Slab	2012	7,500		20	375	375	1,156	3
4	Install Emergency Generator	2012	221,840		20	11,092	11,092	34,200	4
5	Repair Water Chiller	2012	5,944		20	297	297	916	5
6	4Th Fl Dayroom- Wallcovering, Painting, Window Treatments	2012	6,784		20	339	339	1,046	6
7	4Th Floordayroom: Wallcoverings,Handrails,Bump.Guards,Wind	2012	162,781		20	8,139	8,139	25,095	7
8	Roof Patching And Wall Flashing	2012	3,200		20	160	160	493	8
9	Asphalt Surface Sealing	2012	3,170		20	159	159	489	9
10	Med Room Doors On All 5 Floors	2013	7,767		20	777	777	2,330	10
11	Fire Alarm System	2013	3,133		20	313	313	940	11
12	5 Metal Door Frames On 2Nd, 3Rd, 4Th, 5Th, 6Th Floors	2013	6,100		20	610	610	1,779	12
13	2Nd Floor Bed Outlets	2013	13,500		20	1,350	1,350	3,713	13
14	Stairway Handrail	2013	7,250		20	725	725	2,175	14
15	Chiller Repair	2013	6,522		20	544	544	1,359	15
16	Drain Piping Repair From North & South Walls	2013	3,460		20	346	346	807	16
17	Door For 6Th Floor Oxygen Room	2013	2,609		20	130	130	380	17
18	2 Space Heaters	2014	6,900		20	345	345	604	18
19	Elevator Maintenance	2014	6,450		20	323	323	376	19
20	Cable & Alarm System Work	2014	3,691		20	185	185	261	20
21	Cable Work - Wireless Access Points	2015	99,206		20	1,652	1,652	1,652	21
22	Installation Of Outlets For Computer Screens	2015	2,500		20	83	83	83	22
23	Smoking Shelter Canopy Over Patio Area	2015	26,200		20	872	872	872	23
24	Flooring,Walcovering,Acoustical Ceilings,Fixtures In Basement	2015							24
25	Corridor,Therapy Room, Therapy Bathroom	2015	214,145		20	7,702	7,702	7,702	25
26	Dialysis Unit-Plumbing,Nurses Stations,Floor,Acoustical Ceilings	2015	77,795		20	3,890	3,890	3,890	26
27	Ran Conduit & Wire - Repair Of Fire Alarm System	2015	3,098		20	155	155	155	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,905,569	$ 329,290		$ 171,703	$ (157,587)	$ 5,328,676	34

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

Facility Name & ID Number Mid America Care Center, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 6,905,569	$ 329,290		$ 171,703	$ (157,587)	$ 5,328,676	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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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)		$ 6,905,569	$ 329,290		$ 171,703	$ (157,587)	$ 5,328,676	34

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

Facility Name & ID Number Mid America Care Center, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 6,905,569	$ 329,290		$ 171,703	$ (157,587)	$ 5,328,676	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)		$ 6,905,569	$ 329,290		$ 171,703	$ (157,587)	$ 5,328,676	34

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

Facility Name & ID Number Mid America Care Center, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 6,905,569	$ 329,290		$ 171,703	$ (157,587)	$ 5,328,676	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)		$ 6,905,569	$ 329,290		$ 171,703	$ (157,587)	$ 5,328,676	34

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

Facility Name & ID Number Mid America Care Center, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	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, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

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
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, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from 4600 Touhy LLC	2012	98,069	2,514	30	3,269	755	13,076	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Mosaic	2013	1,646	316	20	82	(234)	247	9
10	Allocated from Mosaic	2012	20,475	902	20	1,024	122	4,095	10
11									11
12	Allocated from 4600 Touhy LLC	2012	63,156	1,627	20	3,158	1,531	12,631	12
13	Allocated from 4600 Touhy LLC	2013	15,368	361	20	768	407	2,305	13
14	Allocated from 4600 Touhy LLC	2014	1,527	39	20	76	37	153	14
15									15
16	Allocated from Inter Care Ltd	2001	2,201		20	110	110	1,687	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)		$ 202,442	$ 5,759		$ 8,487	$ 2,728	$ 34,194	34

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

Facility Name & ID Number Mid America Care Center, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 202,442	$ 5,759		$ 8,487	$ 2,728	$ 34,194	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)		$ 202,442	$ 5,759		$ 8,487	$ 2,728	$ 34,194	34

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

Facility Name & ID Number Mid America Care Center, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 1,225,642	$ 11,231	$ 144,719	$ 133,488	10	$ 803,606	71
72	Current Year Purchases	53,317		5,264	5,264	10	5,264	72
73	Fully Depreciated Assets	1,177,367				10	1,177,367	73
74								74
75	TOTALS	$ 2,456,327	$ 11,231	$ 149,984	$ 138,753		$ 1,986,238	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	$	$ 1,875	$ 1,875	5	$ 22,507	76
77		AUTOMOBILE	1983							77
78		1994 ALTIMA	1994							78
79		Allocated from Mosaic	2015	18,144	644		(644)	5	18,144	79
80	TOTALS			$ 40,651	$ 644	$ 1,875	$ 1,231		$ 40,651	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)	$ 9,727,610	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 341,165	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 323,561	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (17,604)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,355,565	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Mid America Care Center, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 1,311 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	$	$ 5,363	17
18					18
19					19
20					20
21	TOTAL		$	$ 5,363	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, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Mid America Care Center, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff			Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service		Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs		$		$ 396,573	$		$ 396,573	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				149,554			149,554	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39 - 03	hrs				467,216			467,216	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					303,973		303,973	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						93,742	45,676		139,418	13
14	TOTAL				$		$ 1,107,085	$ 349,649		$ 1,456,734	14

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

STATE OF ILLINOIS

Facility Name & ID Number Mid America Care Center, Llc **#** 0047035 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/15 **(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	$ 443,081	$ 1,660,576	1
2	Cash-Patient Deposits	68,642	68,642	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,653,615	3,479,269	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	206,069	206,544	6
7	Other Prepaid Expenses	36,079	36,079	7
8	Accounts Receivable (owners or related parties)	4,477,084	22,693,027	8
9	Other(specify):	4,080,614	4,318,414	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 11,965,184	$ 32,462,551	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	2,008,915	3,494,652	15
16	Equipment, at Historical Cost	1,137,215	2,397,234	16
17	Accumulated Depreciation (book methods)	(1,722,975)	(7,267,518)	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):	776,701	872,648	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,199,856	$ 3,240,038	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 14,165,040	$ 35,702,589	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,892,159	$ 1,889,660	26
27	Officer's Accounts Payable	35,371	35,371	27
28	Accounts Payable-Patient Deposits	68,642	68,642	28
29	Short-Term Notes Payable	1,080,018	1,080,018	29
30	Accrued Salaries Payable	217,332	217,332	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,050	12,050	31
32	Accrued Real Estate Taxes(Sch.IX-B)		350,857	32
33	Accrued Interest Payable	15,033	40,682	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	7,072,609	7,218,004	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 10,393,214	$ 10,912,616	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)**	$ 10,393,214	$ 30,712,616	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,771,826	$ 4,989,973	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 14,165,040	$ 35,702,589	48

***(See instructions.)**

Facility Name & ID Number Mid America Care Center, Llc **#** 0047035 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,049,299	1	
2	Restatements (describe):		2	
3	**Late Journal Entries**	(411,019)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,638,280	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	283,546	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(150,000)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 133,546	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,771,826	24	*

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

Facility Name & ID Number Mid America Care Center, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 18,467,924	1
2	Discounts and Allowances for all Levels	(4,279,521)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 14,188,403	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,408,413	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,408,413	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	305,451	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	33,285	19
20	Radiology and X-Ray	4,280	20
21	Other Medical Services	5,661	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 348,677	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	279,564	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 279,564	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	137,978	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 137,978	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 17,363,035	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,500,455	31
32	Health Care	5,207,303	32
33	General Administration	4,833,555	33
	B. Capital Expense		
34	Ownership	2,118,508	34
	C. Ancillary Expense		
35	Special Cost Centers	1,718,939	35
36	Provider Participation Fee	700,729	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 17,079,489	40
41	**Income before Income Taxes (line 30 minus line 40)****	283,546	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 283,546	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 11,948,700	44
45	Private Pay - Net Inpatient Revenue	274,269	45
46	Medicare - Net Inpatient Revenue	1,429,761	46
47	Other-(specify) Hospice	258,167	47
48	Other-(specify) Insurance	277,506	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 14,188,403	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.**

Facility Name & ID Number Mid America Care Center, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	1,952	2,176	$ 112,519	$ 51.71	1
2	Assistant Director of Nursing	1,928	2,208	98,725	44.71	2
3	Registered Nurses	42,326	45,676	1,322,670	28.96	3
4	Licensed Practical Nurses	32,711	36,214	934,097	25.79	4
5	CNAs & Orderlies	116,273	129,379	1,485,408	11.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,653	6,377	142,208	22.30	8
9	Activity Director	1,832	2,076	36,943	17.80	9
10	Activity Assistants	13,290	15,158	151,225	9.98	10
11	Social Service Workers	14,990	16,748	292,201	17.45	11
12	Dietician					12
13	Food Service Supervisor	10,224	11,367	187,821	16.52	13
14	Head Cook					14
15	Cook Helpers/Assistants	23,679	26,718	277,154	10.37	15
16	Dishwashers					16
17	Maintenance Workers	7,950	9,120	177,184	19.43	17
18	Housekeepers	27,993	31,566	306,840	9.72	18
19	Laundry	17,732	19,499	211,274	10.84	19
20	Administrator					20
21	Assistant Administrator	2,096	2,400	103,824	43.26	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	25,552	28,560	365,383	12.79	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,671	4,261	61,667	14.47	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	4,488	5,012	206,405	41.18	33
34	TOTAL (lines 1 - 33)	354,340	394,515	$ 6,473,548 *	$ 16.41	34

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

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	632	$ 29,117	01-03	35
36	Medical Director	Monthly	51,120	09-03	36
37	Medical Records Consultant	Monthly	1,600	10-03	37
38	Nurse Consultant	Monthly	76,650	10-03	38
39	Pharmacist Consultant	Monthly	20,638	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	5	260	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	18,600	12-03	45
46	Other(specify)				46
47	Renal Therapy Consult	Monthly	139,932	10a-03	47
48	MDS Consult	Monthly	37,200	10-03	48
49	TOTAL (lines 35 - 48)	637	$ 375,117		49

C. CONTRACT NURSES

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

Facility Name & ID Number Mid America Care Center, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michael Applebaum	Asst. Admin.	0.00%	$ 103,824
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 103,824

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	$ 51,969
FR&R/Marcum LLP	Accounting	21,490
Personnel Planners	Unemployment Consult	3,442
Mosaic Healthcare	Bookkeeping	390,600
ADAR	Cloud Based IT Solutions	10,781
Health Medx LLC	EMR Software	50,645
Galaxy Hosted Software	Clinical & Financial Software	1,672
Ability Network	Billing Software	4,741
American Data	Computer Services	3,198
Creative Tecnology Solutions	Computer Services	1,453
Mosaic Healthcare	Administrative Consultant	329,790
See Supplemental Schedule		299,488
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 1,169,269

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 68,734
Unemployment Compensation Insurance	38,023
FICA Taxes	484,994
Employee Health Insurance	284,584
Employee Meals	49,604
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	2,641
Other Employee Benefits	54,897
Pension Expense	43,971
Safe Harbor Match Expense	40,193
Disability Insurance	4,850
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,072,492

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	19,434
Health Care Worker Background Check	5,403
(Indicate # of checks performed 540)	
Patient Background Checks	
Licenses & Permits	6,367
Dues & Subscriptions	36,164
Allocated from Mosaic Healthcare	9,294
Allocated from 4600 Touhy LLC	12
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 76,673

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,089
Allocated from Mosaic Healthcare	106
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,195

**See instructions.

Facility Name & ID Number Mid America Care Center, Llc # 0047035 Report Period Beginning: 01/01/15 Ending: 12/31/15

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, Llc **#** 0047035 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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- $34,299**

(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. $ **35,223** 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. $ **700,729**
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.