

Facility Name & ID Number BELLA VISTA CARE CENTER

0041780 Report Period Beginning: 1/1/09 Ending: 12/31/09

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>55</u>	Skilled (SNF)	<u>55</u>	<u>20,075</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>55</u>	Intermediate (ICF)	<u>55</u>	<u>20,075</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>110</u>	TOTALS	<u>110</u>	<u>40,150</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	<u>26,048</u>		<u>2,163</u>	<u>28,211</u>	8
9	SNF/PED					9
10	ICF		<u>1,332</u>		<u>1,332</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>26,048</u>	<u>1,332</u>	<u>2,163</u>	<u>29,543</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.58%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
N/A

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

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

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

I. On what date did you start providing long term care at this location?
Date started 3/1/96

J. Was the facility purchased or leased after January 1, 1978?
YES Date 3/1/96 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 53 and days of care provided 2,005

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number **BELLA VISTA CARE CENTER** # **0041780** Report Period Beginning: **1/1/09** Ending: **12/31/09**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	173,911	17,037	8,754	199,702		199,702		199,702		1
2	Food Purchase		166,368		166,368		166,368	(5)	166,363		2
3	Housekeeping	131,775	26,993		158,768		158,768		158,768		3
4	Laundry	67,930	4,449		72,379		72,379		72,379		4
5	Heat and Other Utilities			99,279	99,279		99,279	2,465	101,744		5
6	Maintenance	52,938		55,482	108,420		108,420	2,501	110,921		6
7	Other (specify):*										7
8	TOTAL General Services	426,554	214,847	163,515	804,916		804,916	4,961	809,877		8
	B. Health Care and Programs										
9	Medical Director			8,400	8,400		8,400		8,400		9
10	Nursing and Medical Records	1,268,108	85,021	8,919	1,362,048		1,362,048		1,362,048		10
10a	Therapy	191,743	963	699	193,405		193,405		193,405		10a
11	Activities	67,525	7,769	703	75,997		75,997		75,997		11
12	Social Services	143,326		3,798	147,124		147,124		147,124		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,670,702	93,753	22,519	1,786,974		1,786,974		1,786,974		16
	C. General Administration										
17	Administrative	90,686		98,880	189,566		189,566	(65,514)	124,052		17
18	Directors Fees										18
19	Professional Services			142,684	142,684		142,684	(2,741)	139,943		19
20	Dues, Fees, Subscriptions & Promotions			56,948	56,948		56,948	(29,399)	27,549		20
21	Clerical & General Office Expenses	142,909	27,953	34,140	205,002		205,002	45,959	250,961		21
22	Employee Benefits & Payroll Taxes			363,748	363,748		363,748		363,748		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,300	4,300		4,300	186	4,486		24
25	Other Admin. Staff Transportation			15,942	15,942		15,942	5,962	21,904		25
26	Insurance-Prop.Liab.Malpractice			104,987	104,987		104,987	434	105,421		26
27	Other (specify):*							12,170	12,170		27
28	TOTAL General Administration	233,595	27,953	821,629	1,083,177		1,083,177	(32,943)	1,050,234		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,330,851	336,553	1,007,663	3,675,067		3,675,067	(27,982)	3,647,085		29

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

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

Facility Name & ID Number **BELLA VISTA CARE CENTER**

#0041780

Report Period Beginning:

1/1/09

Ending:

12/31/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			61,661	61,661		61,661	45,570	107,231			30
31	Amortization of Pre-Op. & Org.							115	115			31
32	Interest			19,463	19,463		19,463	182,357	201,820			32
33	Real Estate Taxes			62,012	62,012		62,012	1,062	63,074			33
34	Rent-Facility & Grounds			288,580	288,580		288,580	(288,580)				34
35	Rent-Equipment & Vehicles			35,810	35,810		35,810	380	36,190			35
36	Other (specify):*											36
37	TOTAL Ownership			467,526	467,526		467,526	(59,096)	408,430			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			68,923	68,923		68,923		68,923			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			60,225	60,225		60,225		60,225			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			129,148	129,148		129,148		129,148			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,330,851	336,553	1,604,337	4,271,741		4,271,741	(87,078)	4,184,663			45

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

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(44,536)	30		9
10	Interest and Other Investment Income	(10)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(5)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,125)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(25,233)	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	(11,619)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (82,528)		\$	30

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	2	
		Amount	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)	(4,550)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (4,550)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (87,078)		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	2	3	4	
		Yes	No	Amount	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

BHF USE ONLY

48		49		50		51		52	
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BELLA VISTA CARE CENTER

ID# 0041780

Report Period Beginning: 1/1/09

Ending: 12/31/09

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	IL COUNCIL LTC - COPE	\$ (4,555)	20	1
2	MISC INCOME	(203)	21	2
3	TAXES-GENERAL	(136)	21	3
4	PRIOR PERIOD ADJUSTMENT-PROF FEES	(6,725)	19	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(11,619)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BELLA VISTA CARE CENTER# 0041780

Report Period Beginning:

1/1/09

Ending:

12/31/09

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5)	0	0	0	0	0	0	0	0	0	0	(5)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	2,465	0	0	0	0	0	0	0	0	2,465	5
6	Maintenance	0	0	2,501	0	0	0	0	0	0	0	0	2,501	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(5)	0	4,966	0	4,961	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(65,514)	0	0	0	0	0	0	0	0	(65,514)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(6,725)	0	3,984	0	0	0	0	0	0	0	0	(2,741)	19
20	Fees, Subscriptions & Promotions	(29,788)	0	389	0	0	0	0	0	0	0	0	(29,399)	20
21	Clerical & General Office Expenses	(1,464)	0	47,423	0	0	0	0	0	0	0	0	45,959	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	186	0	0	0	0	0	0	0	0	186	24
25	Other Admin. Staff Transportation	0	0	5,962	0	0	0	0	0	0	0	0	5,962	25
26	Insurance-Prop.Liab.Malpractice	0	0	434	0	0	0	0	0	0	0	0	434	26
27	Other (specify):*	0	0	12,170	0	0	0	0	0	0	0	0	12,170	27
28	TOTAL General Administration	(37,977)	0	5,034	0	(32,943)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(37,982)	0	10,000	0	(27,982)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BELLA VISTA CARE CENTER# 0041780

Report Period Beginning:

1/1/09

Ending:

12/31/09

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(44,536)	88,640	1,466	0	0	0	0	0	0	0	0	45,570	30
31	Amortization of Pre-Op. & Org.	0	0	115	0	0	0	0	0	0	0	0	115	31
32	Interest	(10)	180,750	1,617	0	0	0	0	0	0	0	0	182,357	32
33	Real Estate Taxes	0	0	1,062	0	0	0	0	0	0	0	0	1,062	33
34	Rent-Facility & Grounds	0	(288,580)	0	0	0	0	0	0	0	0	0	(288,580)	34
35	Rent-Equipment & Vehicles	0	0	380	0	0	0	0	0	0	0	0	380	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(44,546)	(19,190)	4,640	0	(59,096)	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(82,528)	(19,190)	14,640	0	0	0	0	0	0	0	0	(87,078)	45

Facility Name & ID Number **BELLA VISTA CARE CENTER**

0041780

Report Period Beginning:

1/1/09

Ending:

12/31/09

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		AVAILABLE UPON REQUEST		ROSE GARDEN CARE CENTER, LLC, SKOKI		REAL ESTATE

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 RENT	\$ 288,580	ROSE GARDEN CARE CENTER, LLC	100.00%	\$		\$ (288,580) 1
2	V	30 DEPRECIATION					88,640	88,640 2
3	V	32 INTEREST					180,750	180,750 3
4	V							
5	V							
6	V							
7	V							
8	V							
9	V							
10	V							
11	V							
12	V							
13	V							
14	Total		\$ 288,580			\$	269,390	\$ * (19,190) 14

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

Facility Name & ID Number BELLA VISTA CARE CENTER

0041780

Report Period Beginning: 1/1/09

Ending: 12/31/09

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 Home Office	\$ 98,880	Platinum Health Care, LLC	100.00%	\$	\$(98,880)
16	V	5 Utilities		Platinum Health Care, LLC		2,465	2,465
17	V	6 Repairs & Maintenance		Platinum Health Care, LLC		2,501	2,501
18	V	17 Administrative Salary		Platinum Health Care, LLC		33,366	33,366
19	V	19 Professional Fees		Platinum Health Care, LLC		3,984	3,984
20	V	20 Fees, Subscriptions		Platinum Health Care, LLC		389	389
21	V	21 Clerical Salaries		Platinum Health Care, LLC		41,412	41,412
22	V	21 Office Expenses		Platinum Health Care, LLC		6,011	6,011
23	V	24 Education & Seminars		Platinum Health Care, LLC		186	186
24	V	25 Travel		Platinum Health Care, LLC		5,962	5,962
25	V	26 Insurance		Platinum Health Care, LLC		434	434
26	V	27 Employee Benefits		Platinum Health Care, LLC		12,170	12,170
27	V	30 Depreciation		Platinum Health Care, LLC		569	569
28	V	35 Equipment Rental		Platinum Health Care, LLC		380	380
29	V	31 Amortization		Platinum Health Care, LLC		115	115
30	V	30 Depreciation		Platinum Health Care, LLC		897	897
31	V	32 Interest		Platinum Health Care, LLC		1,617	1,617
32	V	33 Real Estate Taxes		Platinum Health Care, LLC		1,062	1,062
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 98,880			\$ 113,520	\$ * 14,640

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

Facility Name & ID Number

BELLA VISTA CARE CENTER

0041780

Report Period Beginning:

1/1/09

Ending:

12/31/09

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	BEN KLEIN		Administrative		SEE ATTACHED	2	6.90	Mgt Fees	\$	1
2	MARK SHAPIRO		Administrative		SEE ATTACHED	6	15.00	Mgt Fees		2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number BELLA VISTA CARE CENTER

0041780

Report Period Beginning:

1/1/09

Ending: 12/31/09

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 Platinum Health Care, LLC
 Street Address 7444 Long Avenue
 City / State / Zip Code Skokie, IL 60077
 Phone Number (847) 329-4100
 Fax Number (847) 329-7652

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Patient Days	606,157	15	\$ 50,576	\$ 29,543	\$ 2,465	1
2	6	Repairs & Maintenance	Patient Days	606,157	15	51,318	29,543	2,501	2
3	17	Administrative Salary	Patient Days	606,157	15	684,597	684,597	33,366	3
4	19	Professional Fees	Patient Days	606,157	15	81,733	29,543	3,984	4
5	20	Fees, Subscriptions	Patient Days	606,157	15	7,987	29,543	389	5
6	21	Clerical Salaries	Patient Days	606,157	15	849,689	849,689	41,412	6
7	21	Office Expenses	Patient Days	606,157	15	123,336	29,543	6,011	7
8	24	Education & Seminars	Patient Days	606,157	15	3,826	29,543	186	8
9	25	Travel	Patient Days	606,157	15	122,325	29,543	5,962	9
10	26	Insurance	Patient Days	606,157	15	8,909	29,543	434	10
11	27	Employee Benefits	Patient Days	606,157	15	249,694	29,543	12,170	11
12	30	Depreciation	Patient Days	606,157	15	11,677	29,543	569	12
13	35	Equipment Rental	Patient Days	606,157	15	7,792	29,543	380	13
14	31	Amortization	Patient Days	606,157	15	2,355	29,543	115	14
15	30	Depreciation	Patient Days	606,157	15	18,405	29,543	897	15
16	32	Interest	Patient Days	606,157	15	33,183	29,543	1,617	16
17	33	Real Estate Taxes	Patient Days	606,157	15	21,795	29,543	1,062	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,329,197	\$ 1,534,286	\$ 113,520	25

Facility Name & ID Number

BELLA VISTA CARE CENTER

0041780

Report Period Beginning:

1/1/09

Ending:

12/31/09

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	RELATED PARTY: ROSE GARDEN CARE CENTER, LLC									1										
2	AMCORE BANK		X	MORTGAGE						2										
3										3										
4										4										
5										5										
Working Capital																				
6	FIRST BANK		X	LINE OF CREDIT						6										
7										7										
8										8										
9	TOTAL Facility Related									9										
B. Non-Facility Related*																				
10	INTEREST INCOME OFFSET									10										
11										11										
12										12										
13	Allocation from Platinum									13										
14	TOTAL Non-Facility Related									14										
15	TOTALS (line 9+line14)									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.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and

1. Real Estate Tax accrual used on 2008 report.		\$	50,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	52,012	2
3. Under or (over) accrual (line 2 minus line 1).		\$	2,012	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	60,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	62,012	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	64,334	8	
	2005	66,777	9	
	2006	50,735	10	
	2007	49,583	11	
	2008	52,012	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2008	\$	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.

Facility Name & ID Number BELLA VISTA CARE CENTER

0041780

Report Period Beginning:

1/1/09

Ending:

12/31/09

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>	<u>400,860</u>	<u>1998</u>	<u>\$ 126,500</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	400,860		\$ 126,500	3

Facility Name & ID Number **BELLA VISTA CARE CENTER**

0041780

Report Period Beginning:

1/1/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	110	1998		\$ 2,536,069	\$ 65,025	39	\$ 65,025	\$	\$ 734,270
5				884,255	23,615	39	23,615		317,428
6									
7									
8									
	Improvement Type**								
9									
10									
11									
12									
13	SEWER LINE/FIRE RATED WALL	2005		16,205		27.5	589	589	2,625
14	TILE/CARPET	2005		2,583		27.5	94	94	420
15	SIDEWALKS	2006		3,700		15	247	247	865
16	SECURITY LOCKS/CAMERA SYSTEM	2006		11,010		27.5	400	400	1,384
17	GABLE WORK	2006		1,740		27.5	63	63	218
18	ROOFTOP AC & HEAT	2006		12,315		27.5	448	448	1,549
19	BATHROOM REMODEL	2006		2,950		27.5	107	107	370
20	ELECTRIC WORK	2006		2,575		27.5	94	94	325
21	THREE COMPARTMENT SINK & FAUCET	2006		2,000		27.5	73	73	252
22	TILE WORK IN KITCHEN	2006		6,862		27.5	250	250	865
23	GREASE TRAP	2006		3,900		27.5	142	142	349
24	ELECTRICAL WORK	2007		1,750		27.5	64	64	157
25	CABINETS/CLAY TILES	2007		1,793		27.5	65	65	160
26	EXHAUST WORK	2007		19,999		27.5	727	727	1,787
27	ANNUNCIATOR-NURSE STATION	2007		1,172		27.5	43	43	106
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number BELLA VISTA CARE CENTER

0041780

Report Period Beginning:

1/1/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	WALL COVERING REPLACEMENT	2008	\$ 4,095	\$	5	\$ 819	\$ 819	\$ 1,433	37
38	REPLACEMENT OF LEGS ON TABLES	2008	4,234		10	423	423	670	38
39	WATER HEATER	2008	1,500		10	150	150	238	39
40	OUTLET INSTALLATION	2008	585		10	59	59	88	40
41	REPAIR GAPS OVER BUILDING	2008	3,600		40	90	90	128	41
42	SMOKE DETECTORS	2008	6,763		10	676	676	958	42
43	50 GALLON ELECTYRIC AOSMITH HEATER	2008	751		10	75	75	81	43
44	TEN REPAIR KITS OUTSIDE FAUCETS	2008	1,250		10	125	125	135	44
45	PANACEA PULSE AIR & PUMP	2008	3,364		10	336	336	364	45
46	NEW YORK ROOFTOP UNIT	2008	7,800		10	780	780	845	46
47	REDO TWO FACES & PAINT THE CABINET	2008	1,860		10	186	186	202	47
48	LARGE AMT OF GREASE PUMPED	2008	875		10	88	88	95	48
49	STRUCTURAL IMPROVEMENTS-CONTRACT-AM REDMOD	2009	5,000		15	306	306	306	49
50	HVAC UNIT	2009	18,375		10	1,684	1,684	1,684	50
51	REMODEL	2009	9,500		15	581	581	581	51
52	KEYS AND LOCKS	2009	837		10	77	77	77	52
53	FIRE ALARM-REPLACE CONTROL PANEL	2009	2,023		10	135	135	135	53
54	DOORS AND INSTALLATION	2009	7,435		15	289	289	289	54
55	LIGHTING-PERIMETER	2009	3,500		15	117	117	117	55
56	GENERATOR WORK	2009	1,363		12	66	66	66	56
57	VIDEO RECORDER FOR SECURITY	2009	1,295		5	108	108	108	57
58	TEMPORARY POWER FROM GENERATOR	2009	970		12	40	40	40	58
59	GENERATOR PANEL	2009	1,873		12	78	78	78	59
60	ASBESTOS INSPECTION	2009	2,806		10	94	94	94	60
61	KITCHEN PLUMBING REPLACEMENT	2009	9,500		25	32	32	32	61
62	COUNTER TOP FOR NURSES STATION	2009	1,985		15	44	44	44	62
63	REFLECTIVE FILM MIRROR	2009	3,103		10	78	78	78	63
64	ASBESTOS INSPECTION	2009	2,794		10	70	70	70	64
65				28,032			(28,032)		65
66									66
67									67
68	Allocation from Platinum			588		588			68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,619,914	\$ 117,260		\$ 100,239	\$ (17,021)	\$ 1,072,165	70

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

Facility Name & ID Number **BELLA VISTA CARE CENTER**

0041780

Report Period Beginning:

1/1/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 29,215	\$ 4,825	\$ 3,761	\$ (1,064)		\$ 5,156	71
72	Current Year Purchases	50,460	28,804	2,353	(26,451)		2,353	72
73	Fully Depreciated Assets							73
74			878	878				74
75	TOTALS	\$ 79,675	\$ 34,507	\$ 6,992	\$ (27,515)		\$ 7,509	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,826,089	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 151,767	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 107,231	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (44,536)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,079,674	85

**

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

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

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

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: \$ **27,587** 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		2009 FORD	\$	\$ 7,050	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 7,050	21

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. _____/2010 \$ _____

13. _____/2011 \$ _____

14. _____/2012 \$ _____

* 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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.

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

	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		hrs	\$		\$				1
2	Licensed Speech and Language Development Therapist	10a-03	hrs			276			276	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-03	# of prescripts				61,157		61,157	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Lab</u>	39-03					7,766		7,766	12
13	Other (specify): <u>RT</u>	10a-03				423			423	13
14	TOTAL			\$		\$ 699	\$ 68,923		\$ 69,622	14

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

Facility Name & ID Number **BELLA VISTA CARE CENTER**

0041780

Report Period Beginning: **1/1/09**

Ending: **12/31/09**

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/09**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 35,668	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	743,478		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,525		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 800,671	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	109,035		15
16	Equipment, at Historical Cost	79,674		16
17	Accumulated Depreciation (book methods)	(96,043)		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):	214,555		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 307,221	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,107,892	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 147,260	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	415,000		29
30	Accrued Salaries Payable	26,630		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	84,792		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	Accrued Expenses	21,700		36
37	Due Others, Adv. Billing	313,891		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,009,273	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,009,273	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 98,619	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,107,892	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 62,162	1
2	Restatements (describe):		2
3		1	3
4	ROUNDING		4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 62,163	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	36,456	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 36,456	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)	\$ 98,619	24 *

* This must agree with page 17, line 47.

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.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,904,244	1
2	Discounts and Allowances for all Levels	(305,767)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,598,477	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	626,137	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 626,137	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	(16)	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	73,049	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,612	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 76,645	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	10	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC INCOME	203	28
28a	PRIOR PERIOD ADJUSTMENT	6,725	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,928	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,308,197	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	804,916	31
32	Health Care	1,786,974	32
33	General Administration	1,083,177	33
B. Capital Expense			
34	Ownership	467,526	34
C. Ancillary Expense			
35	Special Cost Centers	68,923	35
36	Provider Participation Fee	60,225	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,271,741	40
41	Income before Income Taxes (line 30 minus line 40)**	36,456	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 36,456	43

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

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

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

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

Facility Name & ID Number **BELLA VISTA CARE CENTER**

0041780

Report Period Beginning:

1/1/09

Ending:

12/31/09

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	5,317	5,502	\$ 175,315	\$ 31.86	1
2	Assistant Director of Nursing	159	168	4,537	27.01	2
3	Registered Nurses	6,325	6,508	187,048	28.74	3
4	Licensed Practical Nurses	17,026	17,497	398,818	22.79	4
5	CNAs & Orderlies	38,043	40,191	454,462	11.31	5
6	CNA Trainees					6
7	Licensed Therapist	719	719	45,418	63.17	7
8	Rehab/Therapy Aides	7,414	7,924	146,325	18.47	8
9	Activity Director	2,008	2,081	26,113	12.55	9
10	Activity Assistants	4,584	4,705	41,412	8.80	10
11	Social Service Workers	9,602	9,907	143,326	14.47	11
12	Dietician					12
13	Food Service Supervisor	1,960	2,020	35,059	17.36	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,585	16,588	138,852	8.37	15
16	Dishwashers					16
17	Maintenance Workers	3,091	3,252	52,938	16.28	17
18	Housekeepers	13,124	13,693	131,775	9.62	18
19	Laundry	6,789	6,964	67,930	9.75	19
20	Administrator	1,976	2,060	90,686	44.02	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,480	7,728	142,909	18.49	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	3,001	3,129	47,928	15.32	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	144,203	150,636	\$ 2,330,851 *	\$ 15.47	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	203	\$ 8,754	1-3	35
36	Medical Director	Monthly	8,400	9-3	36
37	Medical Records Consultant	Quarterly	2,919	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	6	372	11-3	44
45	Social Service Consultant	61	3,798	12-3	45
46	Other(specify) <u>Psychiatric Cons</u>	Monthly	6,000	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	270	\$ 30,243		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
LORENE FOUST	Administrator		\$ 90,686	Workers' Compensation Insurance	\$ 105,150	IDPH License Fee	\$	
				Unemployment Compensation Insurance	34,372	Advertising: Employee Recruitment	15,629	
				FICA Taxes	175,737	Health Care Worker Background Check	1,850	
				Employee Health Insurance	38,836	(Indicate # of checks performed <u>145</u>)		
				Employee Meals		Patient Background Checks	90	
				Illinois Municipal Retirement Fund (IMRF)*		ADVERTISING & MARKETING	25,233	
				401K		DUES & SUBSCRIPTIONS	6,798	
				EMPLOYEE BENEFITS-OTHER	9,418	LICENSES	2,883	
				EMPLOYEE PHYSICAL EXAM	235			
						ALLOCATION FROM PLATINUM	389	
						Less: Public Relations Expense	()	
						Non-allowable advertising	(25,233)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 90,686	TOTAL (agree to Schedule V, line 22, col.8)	\$ 363,748	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 27,549	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	4,300
							ALLOCATION FROM PLATINUM	186
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL	\$ 4,486
C. Professional Services								
Vendor/Payee	Type		Amount					
SEE ATTACHED SCHEDULE			\$ 142,684					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 142,684					

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL LTC \$11,220
- (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. \$ 2,475 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 60,225
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
 - c. What percent of all travel expense relates to transportation of nurses and patients? _____
 - d. Have vehicle usage logs been maintained? N/A
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
 - g. Does the facility transport residents to and from day training? 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: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.