FOR BHF USE

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0045500

Facility Name: MORTON TERRACE CARE CENTER

Address: 191 EAST QUEENWOOD ROAD (Number) MORTON (City) 61550 (Zip Code)

County: TAZEWELL

Telephone Number: (309) 866-5331 **Fax #** (309) 866-9376

HFS ID Number:

Date of Initial License for Current Owners: 8/01

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: DARRYL BUEKER **Telephone Number:** (417) 865-8701
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/10 to 12/31/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

Paid Preparer
(Signed) (Date)
(Print Name and Title) DARRYL BUEKER, CPA, PARTNER
(Firm Name & Address) BKD, LLP, P. O. BOX 1190, SPRINGFIELD, MO 65801-1190
(Telephone) (417) 865-8701 Fax # (417) 865-0682

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

Facility Name & ID Number MORTON TERRACE CARE CENTER # 0045500 Report Period Beginning: 1/1/10 Ending: 12/31/10

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	44	Skilled (SNF)	44	16,060	1
2		Skilled Pediatric (SNF/PED)			2
3	120	Intermediate (ICF)	120	43,800	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	164	TOTALS	164	59,860	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	33,283		5,162	38,445	8
9	SNF/PED					9
10	ICF		6,172		6,172	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,283	6,172	5,162	44,617	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.54%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 7/18/01

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 7/18/01 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 44 and days of care provided 4,399

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: 12/31/10 Fiscal Year: 12/31/10

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

Facility Name & ID Number MORTON TERRACE CARE CENTER # 0045500 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	308,722	24,259	9,224	342,205		342,205		342,205			1
2	Food Purchase		332,609		332,609		332,609	(3,778)	328,831			2
3	Housekeeping	188,438	39,423		227,861		227,861		227,861			3
4	Laundry	95,923	22,459	5,097	123,479		123,479		123,479			4
5	Heat and Other Utilities			167,099	167,099		167,099	3,997	171,096			5
6	Maintenance	67,792	1,228	133,967	202,987		202,987	3,750	206,737			6
7	Other (specify):*											7
8	TOTAL General Services	660,875	419,978	315,387	1,396,240		1,396,240	3,969	1,400,209			8
	B. Health Care and Programs											
9	Medical Director			9,974	9,974		9,974		9,974			9
10	Nursing and Medical Records	1,934,057	148,986	12,226	2,095,269		2,095,269		2,095,269			10
10a	Therapy	466,348	6,751		473,099		473,099		473,099			10a
11	Activities	262,443	8,471	14,068	284,982		284,982		284,982			11
12	Social Services	67,974		2,919	70,893		70,893		70,893			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,730,822	164,208	39,187	2,934,217		2,934,217		2,934,217			16
	C. General Administration											
17	Administrative	100,283		884,485	984,768		984,768	(412,754)	572,014			17
18	Directors Fees											18
19	Professional Services			221,521	221,521		221,521	1,561	223,082			19
20	Dues, Fees, Subscriptions & Promotions			61,655	61,655		61,655	(27,907)	33,748			20
21	Clerical & General Office Expenses	287,460	47,503	83,604	418,567		418,567	66,816	485,383			21
22	Employee Benefits & Payroll Taxes			551,354	551,354		551,354		551,354			22
23	Inservice Training & Education											23
24	Travel and Seminar			14,967	14,967		14,967	353	15,320			24
25	Other Admin. Staff Transportation			43,492	43,492		43,492	774	44,266			25
26	Insurance-Prop.Liab.Malpractice			134,211	134,211		134,211	516	134,727			26
27	Other (specify):*							11,325	11,325			27
28	TOTAL General Administration	387,743	47,503	1,995,289	2,430,535		2,430,535	(359,316)	2,071,219			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,779,440	631,689	2,349,863	6,760,992		6,760,992	(355,347)	6,405,645			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 MORTON TERRACE CARE CENTER #0045500 Report Period Beginning: 1/1/10 Ending: 12/31/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			(4,824)	(4,824)		(4,824)	567,956	563,132			30
31	Amortization of Pre-Op. & Org.							281	281			31
32	Interest			5,038	5,038		5,038	287,617	292,655			32
33	Real Estate Taxes			73,734	73,734		73,734	1,343	75,077			33
34	Rent-Facility & Grounds			447,338	447,338		447,338	(447,338)				34
35	Rent-Equipment & Vehicles			114,287	114,287		114,287	209	114,496			35
36	Other (specify):*											36
37	TOTAL Ownership			635,573	635,573		635,573	410,068	1,045,641			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			179,247	179,247		179,247		179,247			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			90,885	90,885		90,885		90,885			42
43	Other (specify):*							(74,827)	(74,827)			43
44	TOTAL Special Cost Centers			270,132	270,132		270,132	(74,827)	195,305			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,779,440	631,689	3,255,568	7,666,697		7,666,697	(20,106)	7,646,591			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 MORTON TERRACE CARE CENTER # 0045500 Report Period Beginning: 1/1/10 Ending: 12/31/10

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,760)	2		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	2,091	30		9
10	Interest and Other Investment Income	(14,185)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(18)	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	(3,640)	21		18
19	Entertainment				19
20	Contributions	(4,410)	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	(23,286)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(13,943)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(314,410)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (375,561)		$	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)	355,455		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 355,455		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (20,106)		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

MORTON TERRACE CARE CENTER

ID# 0045500

Report Period Beginning: 1/1/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	IL COUNCIL LTC - COPE	$ (5,773)	20	1
2	TRAVEL-AIRPLANE EXPENSE	(4,278)	25	2
3	TAXES-GENERAL	(629)	21	3
4	MARKETING SALARIES	(65,301)	43	4
5	MARKETING EMPLOYEE BENEFITS	(9,526)	43	5
6	MANAGEMENT FEES-PRIOR	(285,878)	17	6
7	DEPR EXP PY ADJ	56,975	30	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**	(314,410)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MORTON TERRACE CARE CENTER **#** 0045500 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,778)	0	0	0	0	0	0	0	0	0	0	(3,778)	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	3,997	0	0	0	0	0	0	0	0	3,997	5
6	Maintenance	0	0	3,750	0	0	0	0	0	0	0	0	3,750	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,778)	0	7,747	0	0	0	0	0	0	0	0	3,969	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	(285,878)	0	(126,876)	0	0	0	0	0	0	0	0	(412,754)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(4,640)	6,201	0	0	0	0	0	0	0	0	1,561	19
20	Fees, Subscriptions & Promotions	(29,059)	0	1,152	0	0	0	0	0	0	0	0	(27,907)	20
21	Clerical & General Office Expenses	(22,622)	0	89,438	0	0	0	0	0	0	0	0	66,816	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	353	0	0	0	0	0	0	0	0	353	24
25	Other Admin. Staff Transportation	(4,278)	0	5,052	0	0	0	0	0	0	0	0	774	25
26	Insurance-Prop.Liab.Malpractice	0	0	516	0	0	0	0	0	0	0	0	516	26
27	Other (specify):*	0	0	11,325	0	0	0	0	0	0	0	0	11,325	27
28	**TOTAL General Administration**	(341,837)	(4,640)	(12,839)	0	0	0	0	0	0	0	0	(359,316)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(345,615)	(4,640)	(5,092)	0	0	0	0	0	0	0	0	(355,347)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MORTON TERRACE CARE CENTER # 0045500 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	59,066	506,402	2,488	0	0	0	0	0	0	0	0	567,956	30
31	Amortization of Pre-Op. & Org.	0	0	281	0	0	0	0	0	0	0	0	281	31
32	Interest	(14,185)	299,413	2,389	0	0	0	0	0	0	0	0	287,617	32
33	Real Estate Taxes	0	0	1,343	0	0	0	0	0	0	0	0	1,343	33
34	Rent-Facility & Grounds	0	(447,338)	0	0	0	0	0	0	0	0	0	(447,338)	34
35	Rent-Equipment & Vehicles	0	0	209	0	0	0	0	0	0	0	0	209	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	44,881	358,477	6,710	0	0	0	0	0	0	0	0	410,068	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):*	(74,827)	0	0	0	0	0	0	0	0	0	0	(74,827)	43
44	TOTAL Special Cost Centers	(74,827)	0	0	0	0	0	0	0	0	0	0	(74,827)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(375,561)	353,837	1,618	0	0	0	0	0	0	0	0	(20,106)	45

Facility Name & ID Number MORTON TERRACE CARE CENTER # 0045500 Report Period Beginning: 1/1/10 Ending: 12/31/10

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
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		

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	RENTAL INCOME	$ 447,338	MORTON TERRACE REALTY, LLC		$	$ (447,338)	1
2	V	30	DEPRECIATION				506,402	506,402	2
3	V	32	INTEREST				270,667	270,667	3
4	V	32	MORTAGE INSURANCE				25,061	25,061	4
5	V	32	AMORTIZATION-LOAN COSTS				3,685	3,685	5
6	V								6
7	V	19	PROFEESIONAL FEES	85,000	PHC CONSULTANTS, LLC		80,360	(4,640)	7
8	V								8
9	V	19	PROFEESIONAL FEES	728	MTS CONSULTING		728		9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 533,066			$ 886,903	$ * 353,837	14

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

Facility Name & ID Number MORTON TERRACE CARE CENTER # 0045500 Report Period Beginning: 1/1/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	HOME OFFICE	$ 142,140	PLATINUM HEALTH CARE, LLC	100.00%	$	$ (142,140)	15
16	V	5	Utilities		PLATINUM HEALTH CARE, LLC		3,997	3,997	16
17	V	6	Repairs & Maintenance		PLATINUM HEALTH CARE, LLC		3,750	3,750	17
18	V	17	Administrative Salary		PLATINUM HEALTH CARE, LLC		15,264	15,264	18
19	V	19	Professional Fees		PLATINUM HEALTH CARE, LLC		6,201	6,201	19
20	V	20	Fees, Subscriptions		PLATINUM HEALTH CARE, LLC		1,152	1,152	20
21	V	21	Clerical Salaries		PLATINUM HEALTH CARE, LLC		79,043	79,043	21
22	V	21	Office Expenses		PLATINUM HEALTH CARE, LLC		10,395	10,395	22
23	V	24	Education & Seminars		PLATINUM HEALTH CARE, LLC		353	353	23
24	V	25	Travel		PLATINUM HEALTH CARE, LLC		5,052	5,052	24
25	V	26	Insurance		PLATINUM HEALTH CARE, LLC		516	516	25
26	V	27	Employee Benefits		PLATINUM HEALTH CARE, LLC		11,325	11,325	26
27	V	30	Depreciation		PLATINUM HEALTH CARE, LLC		1,075	1,075	27
28	V	35	Equipment Rental		PLATINUM HEALTH CARE, LLC		209	209	28
29	V	31	Amortization		PLATINUM HEALTH CARE, LLC		281	281	29
30	V	30	Depreciation		PLATINUM HEALTH CARE, LLC		1,413	1,413	30
31	V	32	Interest		PLATINUM HEALTH CARE, LLC		2,389	2,389	31
32	V	33	Real Estate Taxes		PLATINUM HEALTH CARE, LLC		1,343	1,343	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 142,140			$ 143,758	$ * 1,618	39

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

Facility Name & ID Number MORTON TERRACE CARE CENTER # 0045500 Report Period Beginning: 1/1/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	BEN KLEIN		Administrative	21.68	SEE ATTACHED	2	6.45	Mgt Fees	$ 152,156	17-03	1
2	BRIAN LEVINSON		Administrative	21.67	SEE ATTACHED	5	12.50	Mgt Fees	152,156	17-03	2
3	MARK SHAPIRO		Administrative	21.67	SEE ATTACHED	8	20.00	Mgt Fees	152,156	17-03	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 456,468		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 MORTON TERRACE CARE CENTER # 0045500 Report Period Beginning: 1/1/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: PLATINUM HEALTH CARE, LLC
Street Address: 7444 LONG AVENUE
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847) 329-4100
Fax Number: (847) 329-7652

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Patient Days	581,243	18	$ 52,068	$	44,617	$ 3,997	1
2	6	Repairs & Maintenance	Patient Days	581,243	18	48,848		44,617	3,750	2
3	17	Administrative Salary	Patient Days	581,243	18	198,854	198,854	44,617	15,264	3
4	19	Professional Fees	Patient Days	581,243	18	80,779		44,617	6,201	4
5	20	Fees, Subscriptions	Patient Days	581,243	18	15,003		44,617	1,152	5
6	21	Clerical Salaries	Patient Days	581,243	18	1,029,725	1,029,725	44,617	79,043	6
7	21	Office Expenses	Patient Days	581,243	18	135,424		44,617	10,395	7
8	24	Education & Seminars	Patient Days	581,243	18	4,602		44,617	353	8
9	25	Travel	Patient Days	581,243	18	65,815		44,617	5,052	9
10	26	Insurance	Patient Days	581,243	18	6,717		44,617	516	10
11	27	Employee Benefits	Patient Days	581,243	18	147,536		44,617	11,325	11
12	30	Depreciation	Patient Days	581,243	18	14,004		44,617	1,075	12
13	35	Equipment Rental	Patient Days	581,243	18	2,729		44,617	209	13
14	31	Amortization	Patient Days	581,243	18	3,657		44,617	281	14
15	30	Depreciation	Patient Days	581,243	18	18,405		44,617	1,413	15
16	32	Interest	Patient Days	581,243	18	31,121		44,617	2,389	16
17	33	Real Estate Taxes	Patient Days	581,243	18	17,492		44,617	1,343	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,872,779	$ 1,228,579		$ 143,758	25

Facility Name & ID Number MORTON TERRACE CARE CENTER # 0045500 Report Period Beginning: 1/1/10 Ending: 12/31/10

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			X	MORTGAGE			$	$			$ 270,668	1
2				LOAN COSTS							3,685	2
3				MORTGAGE INSURANCE							25,060	3
4												4
5												5
	Working Capital											
6	BANK OF AMERICA		X	LINE OF CREDIT							5,038	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 304,451	9
	B. Non-Facility Related*											
10	INTEREST INCOME OFFSET										(14,185)	10
11												11
12												12
13	ALLOCATION FROM PLATINUM										2,389	13
14	TOTAL Non-Facility Related						$	$			$ (11,796)	14
15	TOTALS (line 9+line14)						$	$			$ 292,655	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 25,060 **Line #** 32

*** 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 MORTON TERRACE CARE CENTER # 0045500 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 73,200	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.)		$ 73,734	2
3. Under or (over) accrual (line 2 minus line 1).		$ 534	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 73,200	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.		$ 73,734	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	65,705	8
	2006	67,403	9
	2007	69,122	10
	2008	72,576	11
	2009	73,734	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MORTON TERRACE CARE CENTER COUNTY TAZEWELL

FACILITY IDPH LICENSE NUMBER 0045500

CONTACT PERSON REGARDING THIS REPORT DARRYL BUEKER

TELEPHONE (417) 865-8701 FAX #: (417) 865-0682

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-06-29-115-003	NURSING HOME	$ 73,733.98	$ 73,733.98
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 73,733.98	$ 73,733.98

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number MORTON TERRACE CARE CENTER # 0045500 Report Period Beginning: 1/1/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,948 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 [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$ 197,521	1
2					2
3	TOTALS			$ 197,521	3

Facility Name & ID Number MORTON TERRACE CARE CENTER # 0045500 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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			2006		$ 3,140,548	$ 80,527	27.5	$ 114,202	$ 33,675	$ 328,336	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ROOFTOP AC UNIT / CONDENSOR FAN			2001	5,040		27.5	183	183	1,695	9
10	ROOF REPAIRS			2001	1,900		27.5	69	69	643	10
11	DRY PIPE VALVE			2001	2,225		27.5	81	81	746	11
12	DOORS, LOCKS, ROOM SIGNS, WALLPAPER			2002	29,163		27.5	1,060	1,060	10,009	12
13	WALLPAPER			2002	67,200		27.5	2,444	2,444	20,861	13
14	ROOFING, PARKING LOT REPAIR			2002	40,373		27.5	1,468	1,468	12,333	14
15	WATER HEATER, AIR COMPRESSOR			2002	15,986		27.5	581	581	4,826	15
16	ROOF TOP AC, CONCRETE WORK, MIXING VALVE, CLOSERS			2003	8,894		27.5	323	323	2,409	16
17	ROOF REPAIR, CONDENSOR, STORAGE			2004	36,866		27.5	1,341	1,341	8,661	17
18	SECURITY, PAGING SYSTEM			2005	9,400		27.5	342	342	1,868	18
19	GUTTERS, EXHAUST FAN			2005	5,632		27.5	205	205	1,118	19
20	PATIO/WALK REPAIR			2005	1,882		15	125	125	688	20
21	CONCRETE WALK W/ REMOVALS , EXIT SIGNS			2006	6,814		15	454	454	1,930	21
22	RE-ROOF-EAST,WEST, NORTH WINGS AND MANSARD			2006	24,500		27.5	891	891	3,972	22
23	INSTALLATION OF A NEW CARRIER FURNACE			2006	7,355		27.5	267	267	1,191	23
24	FLOORING - LOBBY, DINING ROOM			2006	43,890		27.5	1,596	1,596	7,116	24
25	INSTALLED NEW CONDENSER D-WING (REMOVED $2,100 CAP DI			2006			27.5				25
26	B WING FLOORING			2007	25,000		10	2,500	2,500	10,000	26
27											27
28											28
29	SHOWER ROOM			2007	16,990		27.5	618	618	1,802	29
30	C WING TILE-A.M. REMODELING-CONTRACT PMT			2007	20,000		10	2,000	2,000	7,500	30
31	BATHROOM REMODEL-A.M. REMODELING-CNTRACT PMT			2007	26,000		27.5	945	945	3,465	31
32	HOT WATER HEATER (REMOVED $1,700 CAP DESK AUDIT 2008)			2007			10				32
33	WATER HEATER A WING KITCHEN (REMOVED $1,900 CAP DESK			2007			10				33
34	D WING REM-A.M. REMODELING & DEC, INC-CONTRACT PMT			2007	20,000		27.5	727	727	2,666	34
35	ROOFTOP UNIT			2007	11,540		10	1,154	1,154	4,135	35
36											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 MORTON TERRACE CARE CENTER # 0045500 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	REMODEL RES ROOMS-A.M. REMODELING-CONTRACT P	2007	$ 26,200	$	27.5	$ 953	$ 953	$ 3,415	37
38	INSTALL DRYER (RECLASS $3,709 TO MME CAP DESK AU	2007			10				38
39	INSTALL 3 TON SEER A/C (REMOVE $1,750 CAP DESK AUD	2007			5				39
40	HALL & ROOM VINYL TILES-A.M. REMODELING-CONTRA	2007	56,790		10	5,679	5,679	19,877	40
41	DRAPES (REMOVE $2,424 CAP DESK AUDIT 2008)	2007			5				41
42	A WING - A.M. REMODELING & DEC, INC.-CONTRACT PMT	2007	20,000		27.5	727	727	2,545	42
43	D WING -A.M. REMODELING-CONTRACT PMT	2007	28,040		27.5	1,020	1,020	3,400	43
44	E WING -A.M. REMODELING-CONTRACT PMT	2007	47,790		27.5	1,738	1,738	5,648	44
45	A WING -A.M. REMODELING-CONTRACT PMT	2007	48,540		27.5	1,765	1,765	5,589	45
46	B WING -A.M. REMODELING-CONTRACT PMT	2007	79,540		27.5	2,892	2,892	8,676	46
47	REMODEL HALL, BTY SHOP, OFFICE-CONTRACT PMT	2007	7,960		27.5	289	289	963	47
48	REMODEL VARIOUS ROOMS-A.M. REMODELING-CONTRA	2008	5,925		27.5	215	215	628	48
49	M WING-A.M. REMODELING-CONTRACT PMT	2008	40,000		27.5	1,455	1,455	3,880	49
50	HOT WATER HEATER	2008	2,025		10	203	203	558	50
51	36 SHADOW BOXES	2008	1,804		27.5	66	66	165	51
52	5 SMOKE DETECTORS/INSTALLATION	2008	1,026		10	103	103	249	52
53	DINING ROOM REMODEL-A.M. REMODELING-CONTRACT	2008	9,995		27.5	363	363	877	53
54	CONCRETE RAMP	2008	4,890		15	326	326	761	54
55	FIRE WALL EXTENSION-A.M. REMODELING-CONTRACT I	2008	9,885		27.5	359	359	778	55
56	SMOKE DETECTORS	2008	2,957		10	296	296	617	56
57	FENCE	2008	5,759		15	384	384	800	57
58	ASBESTOS INSPECTION	2009	1,882		5	376	376	721	58
59	WINDOW REPLACEMENTS	2009	40,500		20	2,025	2,025	3,375	59
60	FIRE ALARM CONTROL PANEL	2009	3,835		10	384	384	640	60
61	2 RINNAI WATER HEATERS	2009	12,050		10	1,205	1,205	2,008	61
62	ROOF REPLACEMENT	2009	34,700		10	3,470	3,470	4,627	62
63	NATURAL GAS WATER HEATER	2009	1,157		10	116	116	155	63
64	TANKLESS WATER HEATER	2009	2,850		10	285	285	285	64
65	WINDOW REPLACEMENTS	2009	2,035		20	102	102	102	65
66	THERAPY OFFICE FLOOR COVERING	2009	9,950		10	995	995	995	66
67	THERAPY ROOM CABINETS	2009	9,890		15	659	659	659	67
68	THERAPY ROOM FLOORING	2009	9,990		10	999	999	999	68
69	BATHROOM REMODEL	2009	9,880		27.5	359	359	359	69
70	TOTAL (lines 4 thru 69)		$ 4,105,043	$ 80,527		$ 163,384	$ 82,857	$ 512,321	70

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

Facility Name & ID Number MORTON TERRACE CARE CENTER # 0045500 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		$ 4,105,043	$ 80,527		$ 163,384	$ 82,857	$ 512,321	1
2	REMODEL ROOMS	2009	9,420		27.5	343	343	343	2
3	REMODEL ROOMS 3&4	2009	9,420		27.5	343	343	343	3
4	REMODEL ROOMS 5&6	2009	9,420		27.5	343	343	343	4
5	REMODEL ROOMS 6&7	2009	9,420		27.5	343	343	343	5
6	100,000 BTU FURNACE	2009	2,295		10	230	230	230	6
7	TRANSFORMER/MOTHER BOARD ON GENERATOR	2010	2,626		5	219	219	219	7
8	INSTALLATION/TESTING NETWORK CABLE	2010	2,635		20	44	44	44	8
9	AUTOMATIC FIRE SPRINKLER	2010	16,740		25	56	56	56	9
10	WINDOW REPLACEMENT	2010	14,873		20	124	124	124	10
11				48,402			(48,402)		11
12				42,418			(42,418)		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	ALLOCATION FROM PLATINUM			1,074		1,074			30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,181,892	$ 172,421		$ 166,503	$ (5,918)	$ 514,366	34

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

Facility Name & ID Number MORTON TERRACE CARE CENTER # 0045500 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	$ 2,527,105	$ 384,479	$ 395,011	$ 10,532		$ 1,926,538	71
72	Current Year Purchases	2,727	2,727	204	(2,523)		204	72
73	Fully Depreciated Assets							73
74	Allocation from Platinum		1,414	1,414				74
75	TOTALS	$ 2,529,832	$ 388,620	$ 396,629	$ 8,009		$ 1,926,742	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)	$ 6,909,245	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 561,041	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 563,132	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,091	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,441,108	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number MORTON TERRACE CARE CENTER # 0045500 Report Period Beginning: 1/1/10 Ending: 12/31/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ $83,863 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		See Attached Schedule	$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	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 MORTON TERRACE CARE CENTER # 0045500 Report Period Beginning: 1/1/10 Ending: 12/31/10

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 MORTON TERRACE CARE CENTER # 0045500 Report Period Beginning: 1/1/10 Ending: 12/31/10

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		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							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	39-02	# of prescrpts				158,705		158,705	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Lab and X-ray	39-02					20,542		20,542	13
14	TOTAL			$		$	$ 179,247		$ 179,247	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 MORTON TERRACE CARE CENTER # 0045500 Report Period Beginning: 1/1/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10 (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	$ 245,143	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,033,526		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	52,651		6
7	Other Prepaid Expenses	3,733		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Others, Escrow	3,283,733		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,618,786	$	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	461,648		15
16	Equipment, at Historical Cost	139,208		16
17	Accumulated Depreciation (book methods)	(379,288)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 221,568	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,840,354	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 523,620	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	116,000		29
30	Accrued Salaries Payable	213,391		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	73,200		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	108,672		36
37	Adv Billing	284,622		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,319,505	$	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)**	$ 1,319,505	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,520,849	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,840,354	$	48

***(See instructions.)**

Facility Name & ID Number MORTON TERRACE CARE CENTER # 0045500 Report Period Beginning: 1/1/10 Ending: 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,098,169	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,098,169	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,422,805	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	(125)	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)**	$ 1,422,680	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)**	$ 3,520,849	24 *

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

Facility Name & ID Number MORTON TERRACE CARE CENTER # 0045500 Report Period Beginning: 1/1/10 Ending: 12/31/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,138,644	1
2	Discounts and Allowances for all Levels	929,685	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,068,329	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,735,500	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,735,500	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	3,760	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	252,070	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,858	19
20	Radiology and X-Ray	3,800	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 271,488	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	14,185	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 14,185	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,089,502	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,396,240	31
32	Health Care	2,934,217	32
33	General Administration	2,430,535	33
	B. Capital Expense		
34	Ownership	635,573	34
	C. Ancillary Expense		
35	Special Cost Centers	179,247	35
36	Provider Participation Fee	90,885	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,666,697	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,422,805	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,422,805	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 MORTON TERRACE CARE CENTER # 0045500 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	2,377	2,601	$ 78,531	$ 30.19	1
2	Assistant Director of Nursing	3,289	3,591	85,534	23.82	2
3	Registered Nurses	4,042	4,482	122,119	27.25	3
4	Licensed Practical Nurses	25,780	29,009	677,873	23.37	4
5	CNAs & Orderlies	67,322	80,250	938,051	11.69	5
6	CNA Trainees					6
7	Licensed Therapist	2,130	2,379	125,286	52.66	7
8	Rehab/Therapy Aides	11,127	12,697	338,909	26.69	8
9	Activity Director	3,939	4,318	78,364	18.15	9
10	Activity Assistants	15,377	16,591	184,079	11.10	10
11	Social Service Workers	3,825	3,956	67,974	17.18	11
12	Dietician					12
13	Food Service Supervisor	3,345	3,494	55,932	16.01	13
14	Head Cook					14
15	Cook Helpers/Assistants	24,436	27,302	252,790	9.26	15
16	Dishwashers					16
17	Maintenance Workers	5,098	5,596	67,792	12.11	17
18	Housekeepers	18,517	19,804	188,438	9.52	18
19	Laundry	8,064	9,446	95,923	10.15	19
20	Administrator	2,056	2,400	100,283	41.78	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,758	17,885	287,460	16.07	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,768	1,985	34,102	17.18	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	218,250	247,786	$ 3,779,440 *	$ 15.25	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	168	$ 9,224	01-03	35
36	Medical Director	Monthly	9,974	09-03	36
37	Medical Records Consultant	Quarterly	1,760	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant		10,466	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	187	11,006	11-03	44
45	Social Service Consultant	49	2,919	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	404	$ 45,349		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 MORTON TERRACE CARE CENTER # 0045500 Report Period Beginning: 1/1/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
CAROLYN CONOVER	ADMINISTRATOR		$ 61,167
WILLIAM WADE	ADMINISTRATOR		39,116
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 100,283

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
SEE ATTACHED SCHEDULE		$ 221,521
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 221,521

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 136,005
Unemployment Compensation Insurance	47,317
FICA Taxes	276,422
Employee Health Insurance	81,454
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K	1,054
EMPLOYEE BENEFITS-OTHER	7,560
EMPLOYEE PHYSICAL EXAM	1,542
TOTAL (agree to Schedule V, line 22, col.8)	$ 551,354

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	14,083
Health Care Worker Background Check	2,720
(Indicate # of checks performed 65)	
Patient Background Checks 126	
ADVERTISING & MARKETING	23,286
DUES & SUBSCRIPTIONS	12,339
LICENSES	3,454
ALLOCATION FROM PLATINUM	1,152
Less: Public Relations Expense	( )
Non-allowable advertising	(23,286)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 33,748

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	14,967
ALLOCATION FROM PLATINUM	353
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 15,320

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MORTON TERRACE CARE CENTER # 0045500 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

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

Facility Name & ID Number MORTON TERRACE CARE CENTER # 0045500 Report Period Beginning: 1/1/10 Ending: 12/31/10

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(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 $13,720**

(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. $ **1,510** 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. $ **90,885**
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? **YES**
If YES, attach a complete explanation. SEE ATTACHED SCHEDULES
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **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? Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name:

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

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