FOR BHF USE

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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.

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

I. IDPH License ID Number: 0045518

Facility Name: MORTON VILLA CARE CENTER

Address: 190 EAST QUEENWOOD (Number) MORTON (City) 61550 (Zip Code)

County: TAZEWELL

Telephone Number: (309) 266-9741 **Fax #** (309) 866-9376

HFS ID Number:

Date of Initial License for Current Owners: 7/17/2001

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: 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 VILLA CARE CENTER # 0045518 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	106	Skilled (SNF)	106	38,690	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	106	TOTALS	106	38,690	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	17,354		4,323	21,677	8
9	SNF/PED					9
10	ICF		3,890		3,890	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,354	3,890	4,323	25,567	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.08%

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 7/17/2001

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date 7/17/2001 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 106 and days of care provided 3,907

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 VILLA CARE CENTER # 0045518 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	207,286	15,218	12,710	235,214		235,214		235,214			1
2	Food Purchase		202,040		202,040		202,040	(12)	202,028			2
3	Housekeeping	145,260	15,505		160,765		160,765		160,765			3
4	Laundry	20,368	16,002		36,370		36,370		36,370			4
5	Heat and Other Utilities			126,310	126,310		126,310	2,290	128,600			5
6	Maintenance	48,053	1,625	62,189	111,867		111,867	2,149	114,016			6
7	Other (specify):*											7
8	TOTAL General Services	420,967	250,390	201,209	872,566		872,566	4,427	876,993			8
	B. Health Care and Programs											
9	Medical Director			8,837	8,837		8,837		8,837			9
10	Nursing and Medical Records	1,299,704	97,561	7,426	1,404,691		1,404,691		1,404,691			10
10a	Therapy	372,694		150	372,844		372,844		372,844			10a
11	Activities	67,098	7,007	2,753	76,858		76,858		76,858			11
12	Social Services	63,296		4,700	67,996		67,996		67,996			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,802,792	104,568	23,866	1,931,226		1,931,226		1,931,226			16
	C. General Administration											
17	Administrative	100,070		596,519	696,589		696,589	(305,312)	391,277			17
18	Directors Fees											18
19	Professional Services			207,934	207,934		207,934	(1,087)	206,847			19
20	Dues, Fees, Subscriptions & Promotions			45,691	45,691		45,691	(24,064)	21,627			20
21	Clerical & General Office Expenses	124,271	27,164	71,625	223,060		223,060	38,364	261,424			21
22	Employee Benefits & Payroll Taxes			390,233	390,233		390,233		390,233			22
23	Inservice Training & Education											23
24	Travel and Seminar			13,058	13,058		13,058	202	13,260			24
25	Other Admin. Staff Transportation			31,254	31,254		31,254	1,417	32,671			25
26	Insurance-Prop.Liab.Malpractice			103,876	103,876		103,876	295	104,171			26
27	Other (specify):*							6,490	6,490			27
28	TOTAL General Administration	224,341	27,164	1,460,190	1,711,695		1,711,695	(283,695)	1,428,000			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,448,100	382,122	1,685,265	4,515,487		4,515,487	(279,268)	4,236,219			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 VILLA CARE CENTER #0045518 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			(55,033)	(55,033)		(55,033)	342,157	287,124			30
31	Amortization of Pre-Op. & Org.							161	161			31
32	Interest							188,474	188,474			32
33	Real Estate Taxes			38,761	38,761		38,761	769	39,530			33
34	Rent-Facility & Grounds			298,343	298,343		298,343	(298,343)				34
35	Rent-Equipment & Vehicles			29,647	29,647		29,647	120	29,767			35
36	Other (specify):*											36
37	**TOTAL Ownership**			311,718	311,718		311,718	233,338	545,056			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			263,325	263,325		263,325		263,325			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			58,035	58,035		58,035		58,035			42
43	Other (specify):*							(6,377)	(6,377)			43
44	**TOTAL Special Cost Centers**			321,360	321,360		321,360	(6,377)	314,983			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,448,100	382,122	2,318,343	5,148,565		5,148,565	(52,307)	5,096,258			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 VILLA CARE CENTER # 0045518 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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(6,088)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(12)	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	(6,890)	21		18
19	Entertainment				19
20	Contributions	(2,010)	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	(21,037)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,879)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(103,961)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (142,877)		$	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)	90,570		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 90,570		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (52,307)		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 VILLA CARE CENTER

ID# 0045518

Report Period Beginning: 1/1/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	IL COUNCIL LTC - COPE	$ (3,687)	20	1
2	MISC INCOME	(785)	21	2
3	TAXES-GENERAL	(323)	21	3
4	MARKETING SALARIES	(5,500)	43	4
5	MARKETING EMPLOYEE BENEFITS	(877)	43	5
6	MANAGEMENT FEES - P/Y	(215,179)	17	6
7	TRAVEL EXPENSE	(1,478)	25	7
8	ADJ TO S/L DEPR	123,868	30	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
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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**	(103,961)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MORTON VILLA CARE CENTER # 0045518 **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 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	(12)	0	0	0	0	0	0	0	0	0	0	(12)	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	2,290	0	0	0	0	0	0	0	0	2,290	5
6	Maintenance	0	0	2,149	0	0	0	0	0	0	0	0	2,149	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(12)	0	4,439	0	0	0	0	0	0	0	0	4,427	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	(215,179)	0	(90,133)	0	0	0	0	0	0	0	0	(305,312)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(4,640)	3,553	0	0	0	0	0	0	0	0	(1,087)	19
20	Fees, Subscriptions & Promotions	(24,724)	0	660	0	0	0	0	0	0	0	0	(24,064)	20
21	Clerical & General Office Expenses	(12,887)	0	51,251	0	0	0	0	0	0	0	0	38,364	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	202	0	0	0	0	0	0	0	0	202	24
25	Other Admin. Staff Transportation	(1,478)	0	2,895	0	0	0	0	0	0	0	0	1,417	25
26	Insurance-Prop.Liab.Malpractice	0	0	295	0	0	0	0	0	0	0	0	295	26
27	Other (specify):*	0	0	6,490	0	0	0	0	0	0	0	0	6,490	27
28	**TOTAL General Administration**	(254,268)	(4,640)	(24,787)	0	0	0	0	0	0	0	0	(283,695)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(254,280)	(4,640)	(20,348)	0	0	0	0	0	0	0	0	(279,268)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MORTON VILLA CARE CENTER # 0045518 **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	123,868	216,863	1,426	0	0	0	0	0	0	0	0	342,157	30
31	Amortization of Pre-Op. & Org.	0	0	161	0	0	0	0	0	0	0	0	161	31
32	Interest	(6,088)	193,193	1,369	0	0	0	0	0	0	0	0	188,474	32
33	Real Estate Taxes	0	0	769	0	0	0	0	0	0	0	0	769	33
34	Rent-Facility & Grounds	0	(298,343)	0	0	0	0	0	0	0	0	0	(298,343)	34
35	Rent-Equipment & Vehicles	0	0	120	0	0	0	0	0	0	0	0	120	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	117,780	111,713	3,845	0	0	0	0	0	0	0	0	233,338	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):*	(6,377)	0	0	0	0	0	0	0	0	0	0	(6,377)	43
44	TOTAL Special Cost Centers	(6,377)	0	0	0	0	0	0	0	0	0	0	(6,377)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(142,877)	107,073	(16,503)	0	0	0	0	0	0	0	0	(52,307)	45

Facility Name & ID Number MORTON VILLA CARE CENTER # 0045518 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	$ 298,343	MORTON VILLA REALTY, LLC		$	$ (298,343)	1
2	V	30	DEPRECIATION				216,863	216,863	2
3	V	32	INTEREST				190,330	190,330	3
4	V	32	AMORTIZATION-LOAN COSTS				2,863	2,863	4
5	V								5
6	V								6
7	V								7
8	V	19	PROFESSIONAL FEES	85,000	PHC CONSULTANTS, LLC		80,360	(4,640)	8
9	V								9
10	V	19	PROFESSIONAL FEES	2,679	MTS CONSULTING		2,679		10
11	V								11
12	V								12
13	V								13
14	Total			$ 386,022			$ 493,095	$ * 107,073	14

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

Facility Name & ID Number MORTON VILLA CARE CENTER # 0045518 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	$ 98,880	PLATINUM HEALTH CARE, LLC	100.00%	$	$ (98,880)	15
16	V	5	Utilities		PLATINUM HEALTH CARE, LLC		2,290	2,290	16
17	V	6	Repairs & Maintenance		PLATINUM HEALTH CARE, LLC		2,149	2,149	17
18	V	17	Administrative Salary		PLATINUM HEALTH CARE, LLC		8,747	8,747	18
19	V	19	Professional Fees		PLATINUM HEALTH CARE, LLC		3,553	3,553	19
20	V	20	Fees, Subscriptions		PLATINUM HEALTH CARE, LLC		660	660	20
21	V	21	Clerical Salaries		PLATINUM HEALTH CARE, LLC		45,294	45,294	21
22	V	21	Office Expenses		PLATINUM HEALTH CARE, LLC		5,957	5,957	22
23	V	24	Education & Seminars		PLATINUM HEALTH CARE, LLC		202	202	23
24	V	25	Travel		PLATINUM HEALTH CARE, LLC		2,895	2,895	24
25	V	26	Insurance		PLATINUM HEALTH CARE, LLC		295	295	25
26	V	27	Employee Benefits		PLATINUM HEALTH CARE, LLC		6,490	6,490	26
27	V	30	Depreciation		PLATINUM HEALTH CARE, LLC		616	616	27
28	V	35	Equipment Rental		PLATINUM HEALTH CARE, LLC		120	120	28
29	V	31	Amortization		PLATINUM HEALTH CARE, LLC		161	161	29
30	V	30	Depreciation		PLATINUM HEALTH CARE, LLC		810	810	30
31	V	32	Interest		PLATINUM HEALTH CARE, LLC		1,369	1,369	31
32	V	33	Real Estate Taxes		PLATINUM HEALTH CARE, LLC		769	769	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 98,880			$ 82,377	$ * (16,503)	39

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

Facility Name & ID Number MORTON VILLA CARE CENTER # 0045518 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	Owner	Administrative	21.68	SEE ATTACHED	2	6.45	Mgt Fees	$ 94,153	17-03	1
2	BRIAN LEVINSON	Owner	Administrative	21.67	SEE ATTACHED	5	12.50	Mgt Fees	94,153	17-03	2
3	MARK SHAPIRO	Owner	Administrative	21.67	SEE ATTACHED	8	20.00	Mgt Fees	94,154	17-03	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 282,460		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 VILLA CARE CENTER # 0045518 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	$	25,567	$ 2,290	1
2	6	Repairs & Maintenance	Patient Days	581,243	18	48,848		25,567	2,149	2
3	17	Administrative Salary	Patient Days	581,243	18	198,854	198,854	25,567	8,747	3
4	19	Professional Fees	Patient Days	581,243	18	80,779		25,567	3,553	4
5	20	Fees, Subscriptions	Patient Days	581,243	18	15,003		25,567	660	5
6	21	Clerical Salaries	Patient Days	581,243	18	1,029,725	1,029,725	25,567	45,294	6
7	21	Office Expenses	Patient Days	581,243	18	135,424		25,567	5,957	7
8	24	Education & Seminars	Patient Days	581,243	18	4,602		25,567	202	8
9	25	Travel	Patient Days	581,243	18	65,815		25,567	2,895	9
10	26	Insurance	Patient Days	581,243	18	6,717		25,567	295	10
11	27	Employee Benefits	Patient Days	581,243	18	147,536		25,567	6,490	11
12	30	Depreciation	Patient Days	581,243	18	14,004		25,567	616	12
13	35	Equipment Rental	Patient Days	581,243	18	2,729		25,567	120	13
14	31	Amortization	Patient Days	581,243	18	3,657		25,567	161	14
15	30	Depreciation	Patient Days	581,243	18	18,405		25,567	810	15
16	32	Interest	Patient Days	581,243	18	31,121		25,567	1,369	16
17	33	Real Estate Taxes	Patient Days	581,243	18	17,492		25,567	769	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,872,779	$ 1,228,579		$ 82,377	25

Facility Name & ID Number MORTON VILLA CARE CENTER # 0045518 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	RELATED PARTY - MORTON VILLA REALTY, LLC						$	$			$	1
2	CAPMARK		X	MORTGAGE	$32,733.40	2/28/06	3,414,100	3,234,215	2/28/41	5.3500	190,330	2
3			X	LOAN COSTS	W/O OVER LOAN		100,218				2,863	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$32,733.40		$ 3,514,318	$ 3,234,215			$ 193,193	9
	B. Non-Facility Related*											
10	INTEREST INCOME OFFSET										(6,088)	10
11												11
12												12
13	ALLOCATION FROM PLATINUM										1,369	13
14	TOTAL Non-Facility Related						$	$			$ (4,719)	14
15	TOTALS (line 9+line14)						$ 3,514,318	$ 3,234,215			$ 188,474	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 16,266 **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 VILLA CARE CENTER # 0045518 **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.**	$ 37,200	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.)		$ 38,761	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,561	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 37,200	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.		$ 38,761	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	34,540	8
	2006	35,433	9
	2007	36,337	10
	2008	38,152	11
	2009	38,761	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 VILLA CARE CENTER COUNTY TAZEWELL

FACILITY IDPH LICENSE NUMBER 0045518

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.	06-06-29-301-010	NURSING HOME	$ 38,760.80	$ 38,760.80
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 38,760.80	$ 38,760.80

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 VILLA CARE CENTER # 0045518 Report Period Beginning: 1/1/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,769 B. General Construction Type: Exterior BRICK Frame STEEL 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 [X] 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				$ 159,149	1
2					2
3	TOTALS			$ 159,149	3

Facility Name & ID Number MORTON VILLA CARE CENTER # 0045518 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		$ 2,399,586	$ 56,528	27.5	$ 87,258	$ 30,730	$ 380,878	4
5	ADDED $132,495 PER CAP DESK AUDIT 2008				132,495		27.5	4,818	4,818	14,454	5
6											6
7											7
8											8
	Improvement Type**										
9	MIXING VALVES / REGULATOR BOARD			2001	1,701		27.5	62	62	610	9
10	WINDOWS			2001	1,528		27.5	56	56	606	10
11	PATIO REPAIR			2001	3,550		27.5	129	129	1,317	11
12	EMPLOYEE DOOR KEYPADS			2002	4,303		27.5	156	156	1,378	12
13	ROOF REPAIR			2002	3,620		27.5	132	132	1,225	13
14	PARKING BLOCKS			2002	9,000		27.5	327	327	3,072	14
15	PAINTING/WALLPAPER (REMOVED $8,299 CAP DESK AUDIT 2008			2002	7,615		27.5	277	277	2,215	15
16	HEATING & AIR			2002	2,022		27.5	74	74	665	16
17	HEATING & AIR			2003	4,581		27.5	167	167	1,242	17
18	STEEL COUNTER FIRE DOOR			2003	1,862		27.5	68	68	617	18
19	WATER HEATER			2004	4,918		27.5	179	179	1,156	19
20	CARPET, TILE, BLINDS, TOILETS			2005	5,438		27.5	198	198	1,080	20
21	AIR CONDITIONER (REMOVED $950 CAP DESK AUDIT 2008)			2005			27.5				21
22	SPRINKLERS			2006	3,840		27.5	140	140	624	22
23	INSTALLED NEW DRIP-EDGE AND GAF ROOF			2006	4,862		27.5	177	177	789	23
24	FLOORING IN FRONT LOBBY AND FRONT HALLWAYS			2006	36,410		27.5	1,324	1,324	5,903	24
25	AIR CONDITIONER (REMOVED $2,145 CAP DESK AUDIT 2008)			2006			27.5				25
26	LANDSCAPING			2006	10,000		15	667	667	3,001	26
27	INSTALLATION OF IRRIGATION SYSTEM			2006	10,300		27.5	375	375	1,671	27
28	SHOWER ROOMS			2007	55,000		27.5	2,000	2,000	7,833	28
29	CALL CORDS-12 ROOMS(REMOVED $1,319 CAP DESK AUDIT 2008			2007			10			253	29
30	FURNITURE			2007							30
31	ADDL SHOWER ROOM WORK			2007	3,600		27.5	131	131	491	31
32	INSTALL & PROV OF EXHAUST			2007	3,825		27.5	139	139	521	32
33	16 CHESTS			2007							33
34	DRAPERY PANELS			2007	2,794		7	399	399	1,397	34
35	PARKING LOT PAVEMENT & PATCH			2007	3,725		20	186	186	651	35
36	REMDL BRKRM-A.M. REMODELING & DEC-CONTRACT PM			2007	8,660		27.5	315		1,050	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 VILLA CARE CENTER # 0045518 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	INSPECT & REPAIR ROOF	2007	$ 20,000	$	27.5	$ 727	$ 727	$ 2,453	37
38	CHECK & REPAIR PLUMBING	2007	20,000		27.5	727	727	2,423	38
39	RHEEM 5 TON ROOFTOP UNIT	2007	5,950		27.5	216	216	702	39
40	PTAC UNITS	2007	1,830		27.5	67	67	212	40
41	PTAC UNITS	2007	1,600		27.5	58	58	184	41
42	SIDEWALKS	2007	10,000		20	500	500	1,500	42
43	A&B WING HALLWAYS/RES. RMS-A.M. REMODELING-CO	2008	50,000		30	1,667	1,667	4,723	43
44	2 PTAC UNITS	2008	1,800		10	180	180	510	44
45	AIR CONDITIONER UNITS	2008	2,379		10	238	238	674	45
46	B WING -A.M. REMODELING-CONTRACT PMT	2008	10,000		30	333	333	916	46
47	A WING BACK HALL VINYL TILE-A.M. REMODELING-CON	2008	14,500		10	1,450	1,450	3,988	47
48	A WING DRYWALL -A.M. REMODELING-CONTRACT PMT	2008	15,845		30	528	528	1,452	48
49	B WING LONG/ BACK HALLS-VINYL TILE-A.M. REMODEL	2008	17,850		10	1,785	1,785	4,909	49
50	B WING BACK HALL DRYWALL-A.M. REMODELING-CONT	2008	2,500		30	83	83	229	50
51	A WING LONG HALL -A.M. REMODELING-CONTRACT PM	2008	10,000		30	333	333	916	51
52	M WING -A.M. REMODELING-CONTRACT PMT	2008	11,970		30	399	399	1,031	52
53	A WING ROOMS -A.M. REMODELING-CONTRACT PMT	2008	8,960		30	299	299	747	53
54	M WING HALLWAY -A.M. REMODELING-CONTRACT PMT	2008	37,025		30	1,234	1,234	3,085	54
55	NEW SIDEWALK - JACKSON & SONS CONCRETE	2008	4,890		15	326	326	734	55
56	FRONT OFFICE -A.M. REMODELING-CONTRACT PMT	2008	9,965		30	332	332	775	56
57	A&B WING HALLWAY -A.M. REMODELING-CONTRACT PM	2008	9,700		30	323	323	754	57
58	ENTRYWAY -A.M. REMODELING-CONTRACT PMT	2008	9,975		30	333	333	777	58
59	A WING HALLWAY VINYL FLOOR	2008	9,625		10	963	963	2,247	59
60	2 HEATING/ AC UNITS (REMOVED $1,672 CAP DESK AUDIT	2008			5				60
61	A WING HALLWAY-A.M. REMODELING-CONTRACT PMT	2008	29,800		30	993	993	2,234	61
62	A WING HALL VINYL FLOOR-A.M. REMODELING-CONTR	2008	16,450		5	3,290	3,290	7,128	62
63	B WING HALL VINYL FLOOR-A.M. REMODELING-CONTR	2008	6,895		5	1,379	1,379	2,988	63
64	LOBBY & TV ROOM FURNITURE (REMOVED $1,016 CAP DI	2008			15				64
65	B WING LONG HALL VINYL FLOOR-A.M. REMODEL-CONT	2008	9,702		10	970	970	2,021	65
66	B WING HALL -A.M. REMODELING-CONTRACT PMT	2008	25,803		30	860	860	1,792	66
67	VINYL FLOOR- 6 PATIENT ROOMS-A.M. REMODEL-CONTI	2008	10,848		10	1,085	1,085	2,260	67
68	6 PATIENT ROOMS -A.M. REMODELING-CONTRACT PMT	2008	19,110		30	637	637	1,327	68
69	ROOM 16 VINYL FLOORING -A.M. REMODELING-CONTR I	2008	1,808		10	181	181	377	69
70	TOTAL (lines 4 thru 69)		$ 3,132,015	$ 56,528		$ 122,250	$ 65,407	$ 490,767	70

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

Facility Name & ID Number MORTON VILLA CARE CENTER # 0045518 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		$ 3,132,015	$ 56,528		$ 122,250	$ 65,722	$ 490,767	1
2	ROOM 16 REMODEL -A.M. REMODELING-CONTRACT PMT	2008	3,185		30	106	106	221	2
3	ROOM 21 VINYL FLOOR -A.M. REM (REMOVED $1,808 CAP	2008			10				3
4	ROOM 21 REMODEL -A.M. REMODELING-CONTRACT PMT	2008	3,185		30	106	106	212	4
5	ROOM 37 & 39 VINYL FLOOR-A.M. REMODELING-CONTR	2008	3,616		10	362	362	724	5
6	ROOM 37 & 39 -A.M. REMODELING-CONTRACT PMT	2008	6,370		30	212	212	424	6
7	ROOM 40 & 43 VINYL FLOOR-A.M. REMODELING-CONTR	2008	3,616		10	362	362	724	7
8	ROOM 40 & 43 -A.M. REMODELING-CONTRACT PMT	2008	6,370		30	212	212	424	8
9	2 HEATING/ AC UNITS	2008	1,672		5	334	334	668	9
10	10 PHOTOELECTRIC SMOKE DET (REMOVED 2,472 CAP DE	2008			10				10
11	ROOM 46 & 53 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	212	212	424	11
12	ROOM 51 & 55 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	212	212	424	12
13	BATHROOM 1-11-16-21 REMODEL-CONTRACT PMT-A.M. R	2009	9,480		30	316	316	632	13
14	ROOM 47 & 49 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	212	212	424	14
15	2 HEATING AIR UNITS (REMOVD $1,720 PER 2010 CAP COS	2009			5				15
16	ROOM 4 & 5 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	212	212	424	16
17	BATHROOM 23-26-37-39 REMODEL-CONTRACT PMT-A.M. I	2009	9,480		30	316	316	606	17
18	ROOM 30 & 32 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	212	212	407	18
19	ROOM 6 & 33 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	212	212	407	19
20	BATHROOM 27-29-40-43 REMODEL-CONTRACT PMT-A.M. I	2009	9,480		30	316	316	606	20
21	ASBESTOS INSPECTION (REMOVED $1,882 PER 2010 CAP C	2009			10				21
22	ROOM 34 & 35 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	212	212	407	22
23	BATHROOM 46-51-53-55 REMODEL-CONTRACT PMT-A.M. I	2009	9,480		30	316	316	606	23
24	ROOM 42 & 44 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	212	212	407	24
25	BATHROOM 30-32-47-49 REMODEL-CONTRACT PMT-A.M. I	2009	9,480		30	316	316	579	25
26	ROOM 36 & 38 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	212	212	389	26
27	ROOM 48 &52 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	212	212	389	27
28	BATHROOM 4-5-6-33 REMODEL-CONTRACT PMT-A.M. REM	2009	9,480		30	316	316	579	28
29	ROOM 41 & 24 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	212	212	371	29
30	BATHROOM 34-35-42-44 REMODEL-CONTRACT PMT-A.M. I	2009	6,370		30	212	212	371	30
31	ROOM 22 & 25 REMODEL-CONTRACT-A.M. REMODELING	2009			30				31
32	BATHROOM 36-38-48-52 REMODEL-CONTRACT PMT-A.M. I	2009	9,480		30	316	316	553	32
33	BATHROOM 45-14-56-12 REMODEL-CONTRACT PMT-A.M. I	2009	9,480		30	316	316	553	33
34	TOTAL (lines 1 thru 33)		$ 3,312,309	$ 56,528		$ 129,016	$ 72,488	$ 503,722	34

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

Facility Name & ID Number MORTON VILLA CARE CENTER # 0045518 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 12B, Carried Forward		$ 3,312,309	$ 56,528		$ 129,016	$ 72,488	$ 503,722	1
2	BATHROOM 22-24-25-41 REMODEL-CONTRACT PMT-A.M. I	2009	9,480		30	316	316	553	2
3	ROOM 45 & 14 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	212	212	371	3
4	CONSTR ON BACK PATIO-SLAB-JACKER CONSTRUCTION	2009			30				4
5	ROOM 56 & 12 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	212	212	354	5
6	BATHROOM 7-18-28 REMODEL-CONTRACT PMT-A.M. REM	2009	7,110		30	237	237	395	6
7	3 HEAT/AIR UNITS & 1 AIR/HEAT SLEEVE UNIT	2009	2,624		5	525	525	831	7
8	ROOM 7 REMODEL-CONTRACT-A.M. REMODELING	2009	3,185		30	106	106	168	8
9	BATHROOM 2-3-15-19 REMODEL-CONTRACT PMT-A.M. RE	2009	9,480		30	316	316	500	9
10	ROOM 28 & 18 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	212	212	336	10
11	BATHROOM 9-10-50-54 REMODEL-CONTRACT PMT-A.M. R	2009	9,480		30	316	316	500	11
12	RELOCATE WALK IN COOLER CONDENSOR UNIT (REMOV	2009			5				12
13	ROOM 2 & 3 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	212	212	318	13
14	RAISE SLAB E & SE CORNER OF BLDG-SLAB-JACKER CON	2009			20				14
15	ROOM 15 & 19 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	212	212	318	15
16	ADD'L SLABS RAISED-SLAB-JACKER CONSTRUCTION (RE	2009			20				16
17	ROOF REPAIR-MARK'S CONSTRUCTION ENTERPRISE	2009	29,900		27.5	1,087	1,087	1,540	17
18	ROOM 50 & 54 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	212	212	300	18
19									19
20	ROOM 9 & 10 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	212	212	300	20
21	WINDOW REPLACEMENT-AMERICAN SIDING (REMOVED	2009			30				21
22	ROOM 13 & 17 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	212	212	283	22
23	THERAPY RM/FRONT OFFICE-REPAIR WATER DAMAAGE	2009	9,325		27.5	339	339	452	23
24	WINDOW REPLACEMENT-CONTRACT-A.M. REMODELING	2009	17,600		30	587	587	709	24
25	2 HEATING AIR UNITS (REMOVED $1,760 PER 2010 CAP CO	2009			5				25
26	33 NEW REPLACEMENT WINDOWS-A.M. REMODELING	2009	4,125		30	138	138	149	26
27	ROOM 8 REMODEL-CONTRACT-A.M. REMODELING	2009	4,993		30	166	166	180	27
28	BATHROOM 8-13-17 REMODEL-CONTRACT PMT-A.M. REM	2009	7,100		30	237	237	257	28
29	VINYL FLOOR ROOM 46,53,51,55-CONTRACT-A.M. REMOD	2009	7,232		10	723	723	1,446	29
30	VINYL FLOOR ROOM 47,49-CONTRACT-A.M. REMODELIN	2009	3,616		10	362	362	724	30
31	VINYL FLOOR ROOM 4,5-CONTRACT-A.M. REMODELING	2009	3,616		10	362	362	724	31
32	VINYL FLOOR ROOM 30,32-CONTRACT-A.M. REMODELIN	2009	3,616		10	362	362	693	32
33	VINYL FLOOR ROOM 6,33-CONTRACT-A.M. REMODELING	2009	3,616		10	362	362	693	33
34	TOTAL (lines 1 thru 33)		$ 3,499,367	$ 56,528		$ 137,253	$ 80,725	$ 516,816	34

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

Facility Name & ID Number MORTON VILLA CARE CENTER # 0045518 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 12C, Carried Forward		$ 3,499,367	$ 56,528		$ 137,253	$ 80,725	$ 516,816	1
2	VINYL FLOOR ROOM 34,35-CONTRACT-A.M. REMODELIN	2009	3,616		10	362	362	693	2
3	VINYL FLOOR ROOM 42,44-CONTRACT-A.M. REMODELIN	2009	3,616		10	362	362	693	3
4	VINYL FLOOR ROOM 36,28-CONTRACT-A.M. REMODELIN	2009	3,616		10	362	362	663	4
5	VINYL FLOOR ROOM 48,52-CONTRACT-A.M. REMODELIN	2009	3,616		10	362	362	663	5
6	VINYL FLOOR ROOM 41,24-CONTRACT-A.M. REMODELIN	2009	3,616		10	362	362	633	6
7	VINYL FLOOR ROOM 34,3542,44-CONTRACT-A.M. REMODE	2009	3,616		10	362	362	633	7
8	VINYL FLOOR ROOM 45,14-CONTRACT-A.M. REMODELIN	2009	3,616		10	362	362	633	8
9	VINYL FLOOR ROOM 56,12-CONTRACT-A.M. REMODELIN	2009	3,616		10	362	362	603	9
10	VINYL FLOOR ROOM 2,3-CONTRACT-A.M. REMODELING	2009	3,616		10	362	362	543	10
11	VINYL FLOOR ROOM 15,16-CONTRACT-A.M. REMODELIN	2009	3,616		10	362	362	543	11
12	VINYL FLOOR ROOM 50,54-CONTRACT-A.M. REMODELIN	2009	3,616		10	362	362	513	12
13	VINYL FLOOR ROOM 9,10-CONTRACT-A.M. REMODELING	2009	3,616		10	362	362	513	13
14	VINYL FLOOR ROOM 13,17-CONTRACT-A.M. REMODELIN	2009	3,616		10	362	362	483	14
15	VINYL FLOOR ROOM 7-CONTRACT-A.M. REMODELING	2009	1,808		10	181	181	286	15
16	VINYL FLOOR ROOM 28,18-CONTRACT-A.M. REMODELIN	2009	3,616		10	362	362	573	16
17	4 HEATING/AIR UNITS	2010	3,445		5	689	689	689	17
18	PIPED NEW RUN OF SPRINKLER	2010	3,420		25	114	114	114	18
19	SPRINKLER COVERAGE FOR ATTIC	2010	8,963		25	299	299	299	19
20	FIRE ALARM SYSTEM CONTROL	2010	4,729		10	355	355	355	20
21	BEDROOM REMODEL-ROOM #20	2010	4,993		30	69	69	69	21
22	RHEEM RTU	2010	4,385		15				22
23									23
24				36,879			(36,879)		24
25				28,759			(28,759)		25
26									26
27									27
28									28
29									29
30	Allocation from Platinum			810		810			30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,581,734	$ 122,976		$ 144,838	$ 21,862	$ 527,010	34

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

Facility Name & ID Number MORTON VILLA CARE CENTER # 0045518 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	$ 920,640	$ 134,220	$ 141,307	$ 7,087		$ 810,234	71
72	Current Year Purchases	3,961	2,264	363	(1,901)		363	72
73	Fully Depreciated Assets							73
74	Allocation from Platinum		616	616				74
75	TOTALS	$ 924,601	$ 137,100	$ 142,286	$ 5,186		$ 810,597	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)	$ 4,665,484	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 260,076	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 287,124	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 27,048	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,337,607	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 VILLA CARE CENTER # 0045518 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

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	$

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 ☒ X NO
16. Rental Amount for movable equipment: $ $29,647 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			$	$	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 VILLA CARE CENTER # 0045518 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 VILLA CARE CENTER # 0045518 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	10a-03	hrs		3	150		3	150	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				233,673		233,673	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					29,652		29,652	13
14	TOTAL			$	3	$ 150	$ 263,325	3	$ 263,475	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 MORTON VILLA CARE CENTER # 0045518 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	$ 49,723	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 3,921)	300,481		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	39,602		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): INSURANCE ESCROW DEP	39,100		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 428,906	$	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	599,452		15
16	Equipment, at Historical Cost	100,807		16
17	Accumulated Depreciation (book methods)	(291,744)		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): DUE TO/FROM R/P	950,283		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,358,798	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,787,704	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 275,677	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	156,977		29
30	Accrued Salaries Payable	134,782		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	37,200		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	ACCRUED EXPENSES	80,182		36
37	DUE OTHERS, ADV BILLING	1,500,875		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,185,693	$	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)**	$ 2,185,693	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (397,989)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,787,704	$	48

***(See instructions.)**

Facility Name & ID Number MORTON VILLA CARE CENTER # 0045518 **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**	$ (945,754)	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (945,753)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	547,764	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)**	$ 547,764	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)**	$ (397,989)	24 *

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

Facility Name & ID Number MORTON VILLA CARE CENTER # 0045518 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	$ 3,396,422	1
2	Discounts and Allowances for all Levels	615,554	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,011,976	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,389,109	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,389,109	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	278,238	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,053	19
20	Radiology and X-Ray	80	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 288,371	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,088	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,088	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC INCOME	785	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 785	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,696,329	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	872,566	31
32	Health Care	1,931,226	32
33	General Administration	1,711,695	33
	B. Capital Expense		
34	Ownership	311,718	34
	C. Ancillary Expense		
35	Special Cost Centers	263,325	35
36	Provider Participation Fee	58,035	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,148,565	40
41	**Income before Income Taxes (line 30 minus line 40)****	547,764	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 547,764	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 VILLA CARE CENTER # 0045518 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	1,736	1,856	$ 62,487	$ 33.67	1
2	Assistant Director of Nursing	2,288	2,364	68,503	28.98	2
3	Registered Nurses	6,234	6,314	168,022	26.61	3
4	Licensed Practical Nurses	18,356	18,728	442,509	23.63	4
5	CNAs & Orderlies	47,622	48,786	534,835	10.96	5
6	CNA Trainees					6
7	Licensed Therapist	2,611	2,878	107,819	37.46	7
8	Rehab/Therapy Aides	8,155	9,109	264,875	29.08	8
9	Activity Director	1,361	1,535	23,236	15.14	9
10	Activity Assistants	4,310	4,535	43,862	9.67	10
11	Social Service Workers	3,582	3,739	63,296	16.93	11
12	Dietician					12
13	Food Service Supervisor	3,868	4,116	66,305	16.11	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,735	15,586	140,981	9.05	15
16	Dishwashers					16
17	Maintenance Workers	2,968	3,075	48,053	15.63	17
18	Housekeepers	15,073	16,370	145,260	8.87	18
19	Laundry	1,734	2,018	20,368	10.09	19
20	Administrator	1,960	2,321	100,070	43.12	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,325	8,671	124,271	14.33	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	1,651	1,980	23,348	11.79	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	146,569	153,981	$ 2,448,100 *	$ 15.90	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	111	$ 6,086	01-03	35
36	Medical Director	Monthly	8,837	09-03	36
37	Medical Records Consultant	Quarterly	1,760	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,666	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	33	1,650	11-03	44
45	Social Service Consultant	81	4,700	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	225	$ 28,699		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 VILLA CARE CENTER # 0045518 Report Period Beginning: 1/1/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
RUTH HUBER	ADMINISTRATOR		$ 96,993
CLINTON DAVID MCDANIEL	ADMINISTRATOR		3,077
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 100,070

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		$ 207,934
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 207,934

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 102,840
Unemployment Compensation Insurance	72,846
FICA Taxes	161,507
Employee Health Insurance	39,104
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K	736
EMPLOYEE BENEFITS-OTHER	12,948
EMPLOYEE PHYSICAL EXAM	252
TOTAL (agree to Schedule V, line 22, col.8)	$ 390,233

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

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	5,654
Health Care Worker Background Check	4,078
(Indicate # of checks performed 81)	
Patient Background Checks 102	
ADVERTISING & MARKETING	21,037
DUES & SUBSCRIPTIONS	8,343
LICENSES	2,892
ALLOCATION FROM PLATINUM	660
Less: Public Relations Expense	( )
Non-allowable advertising	(21,037)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,627

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	13,058
ALLOCATION FROM PLATINUM	202
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,260

**See instructions.

Facility Name & ID Number MORTON VILLA CARE CENTER # 0045518 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 VILLA CARE CENTER **#** 0045518 **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 $8,761**

(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. $ **1,318** 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. $ **58,035**
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 schedule
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 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.