FOR BHF USE

LL1

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

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0045500

Facility Name: MORTON TERRACE CARE CENTER LLC

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 1/1/11 to 12/31/11 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 LLC # 0045500 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	35,868		4,880	40,748	8
9	SNF/PED					9
10	ICF		6,221		6,221	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,868	6,221	4,880	46,969	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.46%

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 4,075

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: 12/31/11 Fiscal Year: 12/31/11

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

Facility Name & ID Number MORTON TERRACE CARE CENTER LLC # 0045500 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	270,232	38,222	9,657	318,111		318,111		318,111			1
2	Food Purchase		361,093		361,093		361,093	(3,789)	357,304			2
3	Housekeeping	199,868	46,623		246,491		246,491		246,491			3
4	Laundry	88,600	22,496	5,629	116,725		116,725		116,725			4
5	Heat and Other Utilities			177,176	177,176		177,176	2,593	179,769			5
6	Maintenance	67,613		127,232	194,845		194,845	3,813	198,658			6
7	Other (specify):*											7
8	TOTAL General Services	626,313	468,434	319,694	1,414,441		1,414,441	2,617	1,417,058			8
	B. Health Care and Programs											
9	Medical Director			6,260	6,260		6,260		6,260			9
10	Nursing and Medical Records	1,936,348	144,409	14,974	2,095,731		2,095,731		2,095,731			10
10a	Therapy	601,240	14,003	6,372	621,615		621,615		621,615			10a
11	Activities	208,516	7,897	18,381	234,794		234,794		234,794			11
12	Social Services	71,970		3,120	75,090		75,090		75,090			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,818,074	166,309	49,107	3,033,490		3,033,490		3,033,490			16
	C. General Administration											
17	Administrative	104,176		149,914	254,090		254,090	(136,688)	117,402			17
18	Directors Fees											18
19	Professional Services			273,359	273,359		273,359	(13,751)	259,608			19
20	Dues, Fees, Subscriptions & Promotions			77,540	77,540		77,540	(34,772)	42,768			20
21	Clerical & General Office Expenses	298,476	34,449	97,515	430,440		430,440	35,927	466,367			21
22	Employee Benefits & Payroll Taxes			566,665	566,665		566,665	(989)	565,676			22
23	Inservice Training & Education											23
24	Travel and Seminar			17,715	17,715		17,715	31	17,746			24
25	Other Admin. Staff Transportation			39,294	39,294		39,294	4,319	43,613			25
26	Insurance-Prop.Liab.Malpractice			113,870	113,870		113,870	(961)	112,909			26
27	Other (specify):*							16,040	16,040			27
28	TOTAL General Administration	402,652	34,449	1,335,872	1,772,973		1,772,973	(130,844)	1,642,129			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,847,039	669,192	1,704,673	6,220,904		6,220,904	(128,227)	6,092,677			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 LLC #0045500 Report Period Beginning: 1/1/11 Ending: 12/31/11

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			12,139	12,139		12,139	283,399	295,538			30
31	Amortization of Pre-Op. & Org.							196	196			31
32	Interest			26,930	26,930		26,930	296,392	323,322			32
33	Real Estate Taxes			76,666	76,666		76,666	1,044	77,710			33
34	Rent-Facility & Grounds			832,532	832,532		832,532	(832,532)				34
35	Rent-Equipment & Vehicles			94,523	94,523		94,523	913	95,436			35
36	Other (specify):*											36
37	TOTAL Ownership			1,042,790	1,042,790		1,042,790	(250,588)	792,202			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			177,651	177,651		177,651		177,651			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):*							(101,179)	(101,179)			43
44	TOTAL Special Cost Centers			268,536	268,536		268,536	(101,179)	167,357			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,847,039	669,192	3,015,999	7,532,230		7,532,230	(479,994)	7,052,236			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 LLC # 0045500 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	(3,764)	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				9
10	Interest and Other Investment Income	(1,046)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(25)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(989)	22		19
20	Contributions	(3,660)	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	(31,501)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(28,644)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(44,030)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (113,659)		$	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)	(366,335)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (366,335)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (479,994)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

MORTON TERRACE CARE CENTER LLC

ID# 0045500

Report Period Beginning: 1/1/11

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	IL COUNCIL LTC - COPE	$ (3,874)	20	1
2	MISC INCOME	(3,349)	21	2
3	TAXES - GENERAL	(1,267)	21	3
4	MARKETING SALARIES	(88,189)	43	4
5	MARKETING EMPLOYEE BENEFITS	(12,990)	43	5
6	ADJ DEPR TO S/L	65,639	30	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(44,030)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MORTON TERRACE CARE CENTER LLC # 0045500 **Report Period Beginning:** 1/1/11 **Ending:** 12/31/11

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	(3,789)	0	0	0	0	0	0	0	0	0	0	(3,789)	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	2,593	0	0	0	0	0	0	0	0	2,593	5
6	Maintenance	0	0	3,813	0	0	0	0	0	0	0	0	3,813	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,789)	0	6,406	0	0	0	0	0	0	0	0	2,617	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(136,688)	0	0	0	0	0	0	0	0	(136,688)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(18,028)	4,277	0	0	0	0	0	0	0	0	(13,751)	19
20	Fees, Subscriptions & Promotions	(35,375)	0	603	0	0	0	0	0	0	0	0	(34,772)	20
21	Clerical & General Office Expenses	(36,920)	0	72,847	0	0	0	0	0	0	0	0	35,927	21
22	Employee Benefits & Payroll Taxes	(989)	0	0	0	0	0	0	0	0	0	0	(989)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	31	0	0	0	0	0	0	0	0	31	24
25	Other Admin. Staff Transportation	0	0	4,319	0	0	0	0	0	0	0	0	4,319	25
26	Insurance-Prop.Liab.Malpractice	0	0	(961)	0	0	0	0	0	0	0	0	(961)	26
27	Other (specify):*	0	0	16,040	0	0	0	0	0	0	0	0	16,040	27
28	**TOTAL General Administration**	(73,284)	(18,028)	(39,532)	0	0	0	0	0	0	0	0	(130,844)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(77,073)	(18,028)	(33,126)	0	0	0	0	0	0	0	0	(128,227)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MORTON TERRACE CARE CENTER LLC # 0045500 **Report Period Beginning:** 1/1/11 **Ending:** 12/31/11

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	65,639	215,135	2,625	0	0	0	0	0	0	0	0	283,399	30
31	Amortization of Pre-Op. & Org.	0	0	196	0	0	0	0	0	0	0	0	196	31
32	Interest	(1,046)	295,791	1,647	0	0	0	0	0	0	0	0	296,392	32
33	Real Estate Taxes	0	0	1,044	0	0	0	0	0	0	0	0	1,044	33
34	Rent-Facility & Grounds	0	(832,532)	0	0	0	0	0	0	0	0	0	(832,532)	34
35	Rent-Equipment & Vehicles	0	0	913	0	0	0	0	0	0	0	0	913	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	64,593	(321,606)	6,425	0	0	0	0	0	0	0	0	(250,588)	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):*	(101,179)	0	0	0	0	0	0	0	0	0	0	(101,179)	43
44	TOTAL Special Cost Centers	(101,179)	0	0	0	0	0	0	0	0	0	0	(101,179)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(113,659)	(339,634)	(26,701)	0	0	0	0	0	0	0	0	(479,994)	45

Facility Name & ID Number MORTON TERRACE CARE CENTER LLC # 0045500 Report Period Beginning: 1/1/11 Ending: 12/31/11

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		SEE PG6-SUPP				

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	$ 832,532	MORTON TERRACE REALTY, LLC		$	$ (832,532)	1
2	V	30	DEPRECIATION				215,135	215,135	2
3	V	32	INTEREST				267,125	267,125	3
4	V	32	MORTGAGE INSURANCE				24,981	24,981	4
5	V	32	AMORTIZATION-LOAN COSTS				3,685	3,685	5
6	V	19	ACCOUNTING FEES				12,500	12,500	6
7	V								7
8	V	19	PROFESSIONAL FEES	134,340	PHC CONSULTANTS, LLC		103,812	(30,528)	8
9	V								9
10	V	19	PROFESSIONAL FEES	2,166	MTS CONSULTING		2,166		10
11	V								11
12	V								12
13	V								13
14	Total			$ 969,038			$ 629,404	$ * (339,634)	14

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

Facility Name & ID Number MORTON TERRACE CARE CENTER LLC # 0045500 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	$ 149,914	PLATINUM HEALTH CARE, LLC	100.00%	$	$ (149,914)	15
16	V	5	Utilities		PLATINUM HEALTH CARE, LLC		2,593	2,593	16
17	V	6	Repairs & Maintenance		PLATINUM HEALTH CARE, LLC		3,813	3,813	17
18	V	17	Administrative Salary		PLATINUM HEALTH CARE, LLC		13,226	13,226	18
19	V	19	Professional Fees		PLATINUM HEALTH CARE, LLC		4,277	4,277	19
20	V	20	Fees, Subscriptions		PLATINUM HEALTH CARE, LLC		603	603	20
21	V	21	Clerical Salaries		PLATINUM HEALTH CARE, LLC		66,135	66,135	21
22	V	21	Office Expenses		PLATINUM HEALTH CARE, LLC		6,712	6,712	22
23	V	24	Education & Seminars		PLATINUM HEALTH CARE, LLC		31	31	23
24	V	25	Travel		PLATINUM HEALTH CARE, LLC		4,319	4,319	24
25	V	26	Insurance		PLATINUM HEALTH CARE, LLC		(961)	(961)	25
26	V	27	Employee Benefits		PLATINUM HEALTH CARE, LLC		16,040	16,040	26
27	V	30	Depreciation		PLATINUM HEALTH CARE, LLC		1,638	1,638	27
28	V	35	Equipment Rental		PLATINUM HEALTH CARE, LLC		913	913	28
29	V	31	Amortization		PLATINUM HEALTH CARE, LLC		196	196	29
30	V	30	Depreciation		PLATINUM HEALTH CARE, LLC		987	987	30
31	V	32	Interest		PLATINUM HEALTH CARE, LLC		1,647	1,647	31
32	V	33	Real Estate Taxes		PLATINUM HEALTH CARE, LLC		1,044	1,044	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 149,914			$ 123,213	$ * (26,701)	39

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

Facility Name & ID Number MORTON TERRACE CARE CENTER LLC # 0045500 Report Period Beginning: 1/1/11 Ending: 12/31/11

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	BEN KLEIN	21.676	ALL FAITH PAVILION	CHICAGO	PLATINUM HEALTH	SKOKIE, IL	MANAGEMENT	1
2	ABM LIMITED PARTNERSHIP	1.11	BELLA VISTA CARE CENTER	PEORIA HEIGHTS	CARE, LLC			2
3	ABRAHAM STERN	4.44	CAPITOL CARE CENTER	SPRINGFIELD	MORTON TERRACE	REALTY, LLC	BUILDING	3
4	BRIAN LEVINSON	21.667	COLONIAL HALL CARE CENTER	PRINCETON	PHC CONSULTANTS	SKOKIE	CONSULTING	4
5	MARK SHAPIRO	21.667	MORTON VILLA CARE CENTER	MORTON	MTS CONSULTING	SKOKIE	CONSULTING	5
6	SUSAN STERN	4.44	RIVER VALLEY SUPPORTING LVG RES	KANKAKEE				6
7	TOM KLEIN	25	RIVERSHORES CARE CENTER	MARSEILLES				7
8			WOOD GLEN PAVILION	WEST CHICAGO				8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number MORTON TERRACE CARE CENTER LL(# 0045500 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	1	3.45	Mgt Fees	$		1
2	BRIAN LEVINSON		Administrative	21.67	SEE ATTACHED	4	10.00	Mgt Fees			2
3	MARK SHAPIRO		Administrative	21.67	SEE ATTACHED	6	15.00	Mgt Fees			3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number MORTON TERRACE CARE CENTER LLC # 0045500 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	876,273	29	$ 48,379	$	46,969	$ 2,593	1
2	6	Repairs & Maintenance	Patient Days	876,273	29	71,131		46,969	3,813	2
3	17	Administrative Salary	Patient Days	876,273	29	246,751	246,751	46,969	13,226	3
4	19	Professional Fees	Patient Days	876,273	29	79,792		46,969	4,277	4
5	20	Fees, Subscriptions	Patient Days	876,273	29	11,255		46,969	603	5
6	21	Clerical Salaries	Patient Days	876,273	29	1,233,841	1,233,841	46,969	66,135	6
7	21	Office Expenses	Patient Days	876,273	29	125,226		46,969	6,712	7
8	24	Education & Seminars	Patient Days	876,273	29	577		46,969	31	8
9	25	Travel	Patient Days	876,273	29	80,576		46,969	4,319	9
10	26	Insurance	Patient Days	876,273	29	(17,938)		46,969	(961)	10
11	27	Employee Benefits	Patient Days	876,273	29	299,243		46,969	16,040	11
12	30	Depreciation	Patient Days	876,273	29	30,566		46,969	1,638	12
13	35	Equipment Rental	Patient Days	876,273	29	17,025		46,969	913	13
14	31	Amortization	Patient Days	876,273	29	3,657		46,969	196	14
15	30	Depreciation	Patient Days	876,273	29	18,405		46,969	987	15
16	32	Interest	Patient Days	876,273	29	30,718		46,969	1,647	16
17	33	Real Estate Taxes	Patient Days	876,273	29	19,475		46,969	1,044	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,298,679	$ 1,480,592		$ 123,213	25

Facility Name & ID Number MORTON TERRACE CARE CENTER LLC # 0045500 Report Period Beginning: 1/1/11 Ending: 12/31/11

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			$	$			$ 267,125	1
2				LOAN COSTS							3,685	2
3				MORTGAGE INSURANCE							24,981	3
4												4
5												5
	Working Capital											
6	BANK OF AMERICA		X	LINE OF CREDIT							7,249	6
7	HFG		X	LINE OF CREDIT							19,681	7
8												8
9	TOTAL Facility Related						$	$			$ 322,721	9
	B. Non-Facility Related*											
10	INTEREST INCOME OFFSET										(1,046)	10
11												11
12												12
13	ALLOCATION FROM PLATINUM										1,647	13
14	TOTAL Non-Facility Related						$	$			$ 601	14
15	TOTALS (line 9+line14)						$	$			$ 323,322	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 24,981 **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 LLC # 0045500 **Report Period Beginning:** 1/1/11 **Ending:** 12/31/11

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 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.)		$ 74,866	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,666	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 75,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 76,666	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	67,403	8
	2007	69,122	9
	2008	72,576	10
	2009	73,734	11
	2010	74,866	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MORTON TERRACE CARE CENTER LLC 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 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-06-29-115-003	NURSING HOME	$ 74,866.16	$ 74,866.16
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 74,866.16	$ 74,866.16

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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 LLC # 0045500 Report Period Beginning: 1/1/11 Ending: 12/31/11

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. [ ] (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 LLC # 0045500 Report Period Beginning: 1/1/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			2006		$ 3,140,548	$ 80,527	27.5	$ 114,202	$ 33,675	$ 442,538	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ROOFTOP AC UNIT / CONDENSOR FAN			2001	5,040		27.5	183	183	1,878	9
10	ROOF REPAIRS			2001	1,900		27.5	69	69	712	10
11	DRY PIPE VALVE			2001	2,225		27.5	81	81	827	11
12	DOORS, LOCKS, ROOM SIGNS, WALLPAPER			2002	29,163		27.5	1,060	1,060	11,069	12
13	WALLPAPER			2002	67,200		27.5	2,444	2,444	23,305	13
14	ROOFING, PARKING LOT REPAIR			2002	40,373		27.5	1,468	1,468	13,801	14
15	WATER HEATER, AIR COMPRESSOR			2002	15,986		27.5	581	581	5,407	15
16	ROOF TOP AC, CONCRETE WORK, MIXING VALVE, CLOSERS			2003	8,894		27.5	323	323	2,732	16
17	ROOF REPAIR, CONDENSOR, STORAGE			2004	36,866		27.5	1,341	1,341	10,002	17
18	SECURITY, PAGING SYSTEM			2005	9,400		27.5	342	342	2,210	18
19	GUTTERS, EXHAUST FAN			2005	5,632		27.5	205	205	1,323	19
20	PATIO/WALK REPAIR			2005	1,882		15	125	125	813	20
21	CONCRETE WALK W/ REMOVALS , EXIT SIGNS			2006	6,814		15	454	454	2,384	21
22	RE-ROOF-EAST,WEST, NORTH WINGS AND MANSARD			2006	24,500		27.5	891	891	4,863	22
23	INSTALLATION OF A NEW CARRIER FURNACE			2006	7,355		27.5	267	267	1,458	23
24	FLOORING - LOBBY, DINING ROOM			2006	43,890		27.5	1,596	1,596	8,712	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	12,500	26
27											27
28											28
29	SHOWER ROOM			2007	16,990		27.5	618	618	2,420	29
30	C WING TILE-A.M. REMODELING-CONTRACT PMT			2007	20,000		10	2,000	2,000	9,500	30
31	BATHROOM REMODEL-A.M. REMODELING-CNTRACT PMT			2007	26,000		27.5	945	945	4,410	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	3,393	34
35	ROOFTOP UNIT			2007	11,540		10	1,154	1,154	5,289	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 LLC # 0045500 Report Period Beginning: 1/1/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	REMODEL RES ROOMS-A.M. REMODELING-CONTRACT P	2007	$ 26,200	$	27.5	$ 953	$ 953	$ 4,368	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	25,556	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	3,272	42
43	D WING -A.M. REMODELING-CONTRACT PMT	2007	28,040		27.5	1,020	1,020	4,420	43
44	E WING -A.M. REMODELING-CONTRACT PMT	2007	47,790		27.5	1,738	1,738	7,386	44
45	A WING -A.M. REMODELING-CONTRACT PMT	2007	48,540		27.5	1,765	1,765	7,354	45
46	B WING -A.M. REMODELING-CONTRACT PMT	2007	79,540		27.5	2,892	2,892	11,568	46
47	REMODEL HALL, BTY SHOP, OFFICE-CONTRACT PMT	2007	7,960		27.5	289	289	1,252	47
48	REMODEL VARIOUS ROOMS-A.M. REMODELING-CONTRA	2008	5,925		27.5	215	215	843	48
49	M WING-A.M. REMODELING-CONTRACT PMT	2008	40,000		27.5	1,455	1,455	5,335	49
50	HOT WATER HEATER	2008	2,025		10	203	203	761	50
51	36 SHADOW BOXES	2008	1,804		27.5	66	66	231	51
52	5 SMOKE DETECTORS/INSTALLATION	2008	1,026		10	103	103	352	52
53	DINING ROOM REMODEL-A.M. REMODELING-CONTRACT	2008	9,995		27.5	363	363	1,240	53
54	CONCRETE RAMP	2008	4,890		15	326	326	1,087	54
55	FIRE WALL EXTENSION-A.M. REMODELING-CONTRACT I	2008	9,885		27.5	359	359	1,137	55
56	SMOKE DETECTORS	2008	2,957		10	296	296	913	56
57	FENCE	2008	5,759		15	384	384	1,184	57
58	ASBESTOS INSPECTION	2009	1,882		5	376	376	1,097	58
59	WINDOW REPLACEMENTS	2009	40,500		20	2,025	2,025	5,400	59
60	FIRE ALARM CONTROL PANEL	2009	3,835		10	384	384	1,024	60
61	2 RINNAI WATER HEATERS	2009	12,050		10	1,205	1,205	3,213	61
62	ROOF REPLACEMENT	2009	34,700		10	3,470	3,470	8,097	62
63	NATURAL GAS WATER HEATER	2009	1,157		10	116	116	271	63
64	TANKLESS WATER HEATER	2009	2,850		10	285	285	570	64
65	WINDOW REPLACEMENTS	2009	2,035		20	102	102	204	65
66	THERAPY OFFICE FLOOR COVERING	2009	9,950		10	995	995	1,990	66
67	THERAPY ROOM CABINETS	2009	9,890		15	659	659	1,318	67
68	THERAPY ROOM FLOORING	2009	9,990		10	999	999	1,998	68
69	BATHROOM REMODEL (RMS 2, 4, 6 & 8)-CONTRACT-A.M. I	2009	9,880		27.5	359	359	718	69
70	TOTAL (lines 4 thru 69)		$ 4,105,043	$ 80,527		$ 163,384	$ 82,857	$ 675,705	70

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

Facility Name & ID Number MORTON TERRACE CARE CENTER LLC # 0045500 Report Period Beginning: 1/1/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,105,043	$ 80,527		$ 163,384	$ 82,857	$ 675,705	1
2	REMODEL ROOMS 1&2-CONTRACT-A.M. REMODELING	2009	9,420		27.5	343	343	686	2
3	REMODEL ROOMS 3&4-CONTRACT-A.M. REMODELING	2009	9,420		27.5	343	343	686	3
4	REMODEL ROOMS 5&6-CONTRACT-A.M. REMODELING	2009	9,420		27.5	343	343	686	4
5	REMODEL ROOMS 7&8 -CONTRACT-A.M. REMODELING	2009	9,420		27.5	343	343	686	5
6	100,000 BTU FURNACE	2009	2,295		10	230	230	460	6
7	TRANSFORMER/MOTHER BOARD ON GENERATOR	2010	2,626		5	525	525	744	7
8	INSTALLATION/TESTING NETWORK CABLE	2010	2,635		20	132	132	176	8
9	AUTOMATIC FIRE SPRINKLER	2010	16,740		25	670	670	726	9
10	WINDOW REPLACEMENT	2010	14,873		20	744	744	868	10
11	WATER HEATERS	2011	3,327		10	305	305	305	11
12	TRENCHING FOR SATTELITE TV	2011	4,824		10	362	362	362	12
13	TV SYSTEM	2011	11,563		10	867	867	867	13
14	KITCHEN WALL-REPAIR & TILE-CONTRACT-A.M. REMOI	2011	3,600		27.5	76	76	76	14
15	FURNACE	2011	4,500		10	263	263	263	15
16	ROOF TOP RHEEM	2011	3,050		10	178	178	178	16
17	PANEL FOR ELECT LOADS	2011	7,298		10	304	304	304	17
18	DIALYSIS UNIT	2011	25,000		27.5	379	379	379	18
19	FIRE SPRINKLER	2011	4,740		25	63	63	63	19
20	ROOF	2011	14,390		27.5	131	131	131	20
21	WATER HEATERS	2011	6,650		10	166	166	166	21
22	FOAM CORE MONUMENT SIGN	2011	2,625		10	44	44	44	22
23	DIALYSIS PLAN	2011	3,990		27.5	12	12	12	23
24				11,527			(11,527)		24
25				23,542			(23,542)		25
26									26
27									27
28									28
29									29
30									30
31	ALLOCATION FROM PLATINUM			740		740			31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,277,449	$ 116,336		$ 170,947	$ 54,611	$ 684,573	34

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

Facility Name & ID Number MORTON TERRACE CARE CENTER LLC # 0045500 Report Period Beginning: 1/1/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 2,529,832	$ 103,286	$ 114,314	$ 11,028		$ 2,043,368	71
72	Current Year Purchases	40,362	8,392	8,392			8,392	72
73	Fully Depreciated Assets							73
74	Allocation from Platinum		1,885	1,885				74
75	TOTALS	$ 2,570,194	$ 113,563	$ 124,591	$ 11,028		$ 2,051,760	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	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)	$ 7,045,164	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 229,899	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 295,538	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 65,639	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,736,333	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 LLC # 0045500 Report Period Beginning: 1/1/11 Ending: 12/31/11

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.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 73,497 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 TERRACE CARE CENTER LLC # 0045500 Report Period Beginning: 1/1/11 Ending: 12/31/11

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 LLC # 0045500 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	10a-03	hrs	$	280	$ 6,372	$	280	$ 6,372	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				157,449		157,449	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Lab & X-ray	39-02					20,202		20,202	13
14	TOTAL			$	280	$ 6,372	$ 177,651	280	$ 184,023	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 LLC # 0045500 Report Period Beginning: 1/1/11 Ending: 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/11 (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	$ 7,043	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,378,787		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	46,075		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	3,660,959		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,092,864	$	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)	(391,427)		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)**	$ 209,429	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,302,293	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 794,346	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,364,486		29
30	Accrued Salaries Payable	240,597		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	75,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	121,514		36
37	Due Others, Adv Billing	221,328		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,817,271	$	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)**	$ 2,817,271	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,485,022	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,302,293	$	48

***(See instructions.)**

Facility Name & ID Number MORTON TERRACE CARE CENTER LLC # 0045500 **Report Period Beginning:** 1/1/11 **Ending:** 12/31/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,520,849	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)**	$ 3,520,848	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	264,493	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	(300,319)	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)**	$ (35,826)	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)**	$ 3,485,022	24 *

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

Facility Name & ID Number MORTON TERRACE CARE CENTER LLC # 0045500 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	$ 6,629,343	1
2	Discounts and Allowances for all Levels	(493,898)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,135,445	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,401,537	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,401,537	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	3,764	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	237,531	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13,691	19
20	Radiology and X-Ray	360	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 255,346	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,046	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,046	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC INCOME	3,349	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,349	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,796,723	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,414,441	31
32	Health Care	3,033,490	32
33	General Administration	1,772,973	33
	B. Capital Expense		
34	Ownership	1,042,790	34
	C. Ancillary Expense		
35	Special Cost Centers	177,651	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)***	$ 7,532,230	40
41	**Income before Income Taxes (line 30 minus line 40)****	264,493	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 264,493	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 LLC # 0045500 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	2,784	2,898	$ 89,696	$ 30.95	1
2	Assistant Director of Nursing	978	1,043	28,693	27.51	2
3	Registered Nurses	3,632	3,713	103,289	27.82	3
4	Licensed Practical Nurses	30,523	31,634	731,721	23.13	4
5	CNAs & Orderlies	77,440	81,332	949,391	11.67	5
6	CNA Trainees					6
7	Licensed Therapist	5,070	5,553	250,572	45.12	7
8	Rehab/Therapy Aides	12,445	13,803	350,668	25.41	8
9	Activity Director	3,628	3,986	63,516	15.93	9
10	Activity Assistants	13,012	13,723	145,000	10.57	10
11	Social Service Workers	3,868	4,049	71,970	17.77	11
12	Dietician					12
13	Food Service Supervisor	2,063	2,209	40,815	18.48	13
14	Head Cook					14
15	Cook Helpers/Assistants	24,124	24,950	229,417	9.20	15
16	Dishwashers					16
17	Maintenance Workers	5,202	5,513	67,613	12.26	17
18	Housekeepers	19,482	20,385	199,868	9.80	18
19	Laundry	8,848	9,367	88,600	9.46	19
20	Administrator	1,923	2,083	104,176	50.01	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,387	17,356	298,476	17.20	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	1,748	1,964	33,558	17.09	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	233,157	245,561	$ 3,847,039 *	$ 15.67	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	176	$ 9,657	1-03	35
36	Medical Director	Monthly	6,260	9-03	36
37	Medical Records Consultant	Quarterly	1,760	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant		13,214	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	174	11,620	11-03	44
45	Social Service Consultant	53	3,120	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	403	$ 45,631		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 LLC # 0045500 Report Period Beginning: 1/1/11 Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
WILLIAM WADE	ADMINISTRATOR		$ 104,176
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 104,176

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		$ 273,359
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 273,359

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 78,347
Unemployment Compensation Insurance	87,935
FICA Taxes	289,902
Employee Health Insurance	98,807
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K	1,200
EMPLOYEE BENEFITS - OTHER	8,409
EMPLOYEE PHYSICAL EXAM	1,076
TOTAL (agree to Schedule V, line 22, col.8)	$ 565,676

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	17,882
Health Care Worker Background Check	4,075
(Indicate # of checks performed 22)	
Patient Background Checks 130	
ADVERTISING & MARKETING	31,501
DUES & SUBSCRIPTIONS	15,928
LICENSES	4,280
ALLOCATION FROM PLATINUM	603
Less: Public Relations Expense	( )
Non-allowable advertising	(31,501)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 42,768

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	17,715
ALLOCATION FROM PLATINUM	31
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 17,746

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MORTON TERRACE CARE CENTER LLC # 0045500 Report Period Beginning: 1/1/11 Ending: 12/31/11

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 LLC # 0045500 **Report Period Beginning:** 1/1/11 **Ending:** 12/31/11

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 $15,612**

(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. $ **1,415** 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.
b. Do you have a separate contract with the Department to provide medical transportation for residents? 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.