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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0045500

Facility Name: MORTON TERRACE CARE CTR

Address: 191 E QUEENWOOD RD (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: PAMELA PHILLIPS **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 1/1/12 to 12/31/12 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 CTR # 0045500 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	16,104	1
2		Skilled Pediatric (SNF/PED)			2
3	120	Intermediate (ICF)	120	43,920	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	164	TOTALS	164	60,024	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	32,388		4,970	37,358	8
9	SNF/PED					9
10	ICF		5,947		5,947	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,388	5,947	4,970	43,305	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.15%

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 [ ] 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 4,139

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

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

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

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	235,930	42,799	9,586	288,315		288,315		288,315			1
2	Food Purchase		407,867		407,867		407,867	(5,300)	402,567			2
3	Housekeeping	206,987	51,783		258,770		258,770		258,770			3
4	Laundry	76,081	27,598	3,764	107,443		107,443		107,443			4
5	Heat and Other Utilities			167,745	167,745		167,745	2,101	169,846			5
6	Maintenance	60,304		158,302	218,606		218,606	3,164	221,770			6
7	Other (specify):*											7
8	**TOTAL General Services**	579,302	530,047	339,397	1,448,746		1,448,746	(35)	1,448,711			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	2,170,818	148,920	18,574	2,338,312		2,338,312		2,338,312			10
10a	Therapy	497,482	7,820	40,150	545,452		545,452		545,452			10a
11	Activities	173,189	11,545	18,787	203,521		203,521		203,521			11
12	Social Services	66,457		3,416	69,873		69,873		69,873			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,907,946	168,285	86,927	3,163,158		3,163,158		3,163,158			16
	C. General Administration											
17	Administrative	106,781		195,009	301,790		301,790	(181,632)	120,158			17
18	Directors Fees											18
19	Professional Services			278,125	278,125		278,125	(6,419)	271,706			19
20	Dues, Fees, Subscriptions & Promotions			55,926	55,926		55,926	(25,137)	30,789			20
21	Clerical & General Office Expenses	214,111	34,434	178,670	427,215		427,215	(57,866)	369,349			21
22	Employee Benefits & Payroll Taxes			749,263	749,263		749,263	(4,198)	745,065			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,866	5,866		5,866	373	6,239			24
25	Other Admin. Staff Transportation			42,832	42,832		42,832	2,810	45,642			25
26	Insurance-Prop.Liab.Malpractice			122,481	122,481		122,481	544	123,025			26
27	Other (specify):*							14,869	14,869			27
28	**TOTAL General Administration**	320,892	34,434	1,628,172	1,983,498		1,983,498	(256,656)	1,726,842			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,808,140	732,766	2,054,496	6,595,402		6,595,402	(256,691)	6,338,711			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 CTR #0045500 Report Period Beginning: 1/1/12 Ending: 12/31/12

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			11,612	11,612		11,612	203,065	214,677			30
31	Amortization of Pre-Op. & Org.							100	100			31
32	Interest			22,863	22,863		22,863	270,729	293,592			32
33	Real Estate Taxes			77,561	77,561		77,561	829	78,390			33
34	Rent-Facility & Grounds			686,032	686,032		686,032	(685,775)	257			34
35	Rent-Equipment & Vehicles			92,311	92,311		92,311	883	93,194			35
36	Other (specify):*											36
37	**TOTAL Ownership**			890,379	890,379		890,379	(210,169)	680,210			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			180,448	180,448		180,448		180,448			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			519,774	519,774		519,774		519,774			42
43	Other (specify):*							(8,377)	(8,377)			43
44	**TOTAL Special Cost Centers**			700,222	700,222		700,222	(8,377)	691,845			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,808,140	732,766	3,645,097	8,186,003		8,186,003	(475,237)	7,710,766			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 CTR # 0045500 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	(5,256)	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	(366)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(44)	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	(9,275)	21		18
19	Entertainment				19
20	Contributions	(102,435)	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	(19,513)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,620)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	34,265			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (105,244)		$	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)	(369,993)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (369,993)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (475,237)		37

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

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

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

MORTON TERRACE CARE CTR

ID# 0045500

Report Period Beginning: 1/1/12

Ending: 12/31/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	IL COUNCIL LTC - COPE	$ (6,138)	20	1
2	MISC INCOME	(4,739)	21	2
3	TAXES-GENERAL	(566)	21	3
4	MARKETING SALARIES	(7,000)	43	4
5	MARKETING EMPLOYEE BENEFITS	(1,377)	43	5
6	ADJ DEPR TO S/L	64,085	30	6
7	CONSULTING FEES	(10,000)	19	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**	34,265		49

STATE OF ILLINOIS

Summary A

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

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,300)	0	0	0	0	0	0	0	0	0	0	(5,300)	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	2,101	0	0	0	0	0	0	0	0	2,101	5
6	Maintenance	0	0	3,164	0	0	0	0	0	0	0	0	3,164	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,300)	0	5,265	0	0	0	0	0	0	0	0	(35)	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	(181,632)	0	0	0	0	0	0	0	0	(181,632)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(10,000)	(3,255)	6,836	0	0	0	0	0	0	0	0	(6,419)	19
20	Fees, Subscriptions & Promotions	(25,651)	0	514	0	0	0	0	0	0	0	0	(25,137)	20
21	Clerical & General Office Expenses	(119,635)	0	61,769	0	0	0	0	0	0	0	0	(57,866)	21
22	Employee Benefits & Payroll Taxes	0	(4,198)	0	0	0	0	0	0	0	0	0	(4,198)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	373	0	0	0	0	0	0	0	0	373	24
25	Other Admin. Staff Transportation	0	0	2,810	0	0	0	0	0	0	0	0	2,810	25
26	Insurance-Prop.Liab.Malpractice	0	0	544	0	0	0	0	0	0	0	0	544	26
27	Other (specify):*	0	0	14,869	0	0	0	0	0	0	0	0	14,869	27
28	**TOTAL General Administration**	(155,286)	(7,453)	(93,917)	0	0	0	0	0	0	0	0	(256,656)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(160,586)	(7,453)	(88,652)	0	0	0	0	0	0	0	0	(256,691)	29

STATE OF ILLINOIS

Summary B

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

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	64,085	136,195	2,785	0	0	0	0	0	0	0	0	203,065	30
31	Amortization of Pre-Op. & Org.	0	0	100	0	0	0	0	0	0	0	0	100	31
32	Interest	(366)	269,671	1,424	0	0	0	0	0	0	0	0	270,729	32
33	Real Estate Taxes	0	0	829	0	0	0	0	0	0	0	0	829	33
34	Rent-Facility & Grounds	0	(686,032)	257	0	0	0	0	0	0	0	0	(685,775)	34
35	Rent-Equipment & Vehicles	0	0	883	0	0	0	0	0	0	0	0	883	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	63,719	(280,166)	6,278	0	0	0	0	0	0	0	0	(210,169)	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):*	(8,377)	0	0	0	0	0	0	0	0	0	0	(8,377)	43
44	TOTAL Special Cost Centers	(8,377)	0	0	0	0	0	0	0	0	0	0	(8,377)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(105,244)	(287,619)	(82,374)	0	0	0	0	0	0	0	0	(475,237)	45

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

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	$ 686,032	MORTON TERRACE REALTY, LLC		$	$ (686,032)	1
2	V	30	DEPRECIATION				136,195	136,195	2
3	V	32	INTEREST				265,986	265,986	3
4	V	32	AMORTIZATION-LOAN COSTS				3,685	3,685	4
5	V								5
6	V								6
7	V								7
8	V	19	PROFESSIONAL FEES	133,200	PHC CONSULTANTS, LLC		129,945	(3,255)	8
9	V	22	EMPLOYEE BENEFITS	4,198	PHC CONSULTANTS, LLC			(4,198)	9
10	V								10
11	V	19	PROFESSIONAL FEES	1,579	MTS CONSULTING		1,579		11
12	V								12
13	V								13
14	Total			$ 825,009			$ 537,390	$ * (287,619)	14

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

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

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	$ 195,009	PLATINUM HEALTH CARE, LLC	100.00%	$	$ (195,009)	15
16	V	5	Utilities		PLATINUM HEALTH CARE, LLC		2,101	2,101	16
17	V	6	Repairs & Maintenance		PLATINUM HEALTH CARE, LLC		3,164	3,164	17
18	V	17	Administrative Salary		PLATINUM HEALTH CARE, LLC		13,377	13,377	18
19	V	19	Professional Fees		PLATINUM HEALTH CARE, LLC		6,836	6,836	19
20	V	20	Fees, Subscriptions		PLATINUM HEALTH CARE, LLC		514	514	20
21	V	21	Clerical Salaries		PLATINUM HEALTH CARE, LLC		56,540	56,540	21
22	V	21	Office Expenses		PLATINUM HEALTH CARE, LLC		5,229	5,229	22
23	V	24	Education & Seminars		PLATINUM HEALTH CARE, LLC		373	373	23
24	V	25	Travel		PLATINUM HEALTH CARE, LLC		2,810	2,810	24
25	V	26	Insurance		PLATINUM HEALTH CARE, LLC		544	544	25
26	V	27	Employee Benefits		PLATINUM HEALTH CARE, LLC		14,869	14,869	26
27	V	30	Depreciation		PLATINUM HEALTH CARE, LLC		1,922	1,922	27
28	V	35	Equipment Rental		PLATINUM HEALTH CARE, LLC		883	883	28
29	V	31	Amortization		PLATINUM HEALTH CARE, LLC		100	100	29
30	V	30	Depreciation		PLATINUM HEALTH CARE, LLC		863	863	30
31	V	32	Interest		PLATINUM HEALTH CARE, LLC		1,424	1,424	31
32	V	33	Real Estate Taxes		PLATINUM HEALTH CARE, LLC		829	829	32
33	V	34	Office Rent		PLATINUM HEALTH CARE, LLC		257	257	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 195,009			$ 112,635	$ * (82,374)	39

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

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

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								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 CTR # 0045500 Report Period Beginning: 1/1/12 Ending: 12/31/12

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	BEN KLEIN		Administrative	21.68	SEE ATTACHED	2	3.85	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	4	10.00	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 CTR # 0045500 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	923,219	30	$ 44,791	$	43,305	$ 2,101	1
2	6	Repairs & Maintenance	Patient Days	923,219	30	67,446		43,305	3,164	2
3	17	Administrative Salary	Patient Days	923,219	30	285,177	285,177	43,305	13,377	3
4	19	Professional Fees	Patient Days	923,219	30	145,744		43,305	6,836	4
5	20	Fees, Subscriptions	Patient Days	923,219	30	10,954		43,305	514	5
6	21	Clerical Salaries	Patient Days	923,219	30	1,205,375	1,205,375	43,305	56,540	6
7	21	Office Expenses	Patient Days	923,219	30	111,487		43,305	5,229	7
8	24	Education & Seminars	Patient Days	923,219	30	7,956		43,305	373	8
9	25	Travel	Patient Days	923,219	30	59,896		43,305	2,810	9
10	26	Insurance	Patient Days	923,219	30	11,602		43,305	544	10
11	27	Employee Benefits	Patient Days	923,219	30	316,988		43,305	14,869	11
12	30	Depreciation	Patient Days	923,219	30	40,988		43,305	1,922	12
13	35	Equipment Rental	Patient Days	923,219	30	18,824		43,305	883	13
14	31	Amortization	Patient Days	923,219	30	2,134		43,305	100	14
15	30	Depreciation	Patient Days	923,219	30	18,405		43,305	863	15
16	32	Interest	Patient Days	923,219	30	30,356		43,305	1,424	16
17	33	Real Estate Taxes	Patient Days	923,219	30	17,678		43,305	829	17
18	34	Office Rent	Patient Days	923,219	30	5,488		43,305	257	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,401,289	$ 1,490,552		$ 112,635	25

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

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			$	$			$ 241,586	1
2				LOAN COSTS							3,685	2
3				MORTGAGE INSURANCE							24,400	3
4												4
5												5
	Working Capital											
6	HFG		X	LINE OF CREDIT							22,863	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 292,534	9
	B. Non-Facility Related*											
10	INTEREST INCOME OFFSET										(366)	10
11												11
12												12
13	ALLOCATION FROM PLATINUM										1,424	13
14	TOTAL Non-Facility Related						$	$			$ 1,058	14
15	TOTALS (line 9+line14)						$	$			$ 293,592	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 24,400 **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 CTR # 0045500 Report Period Beginning: 1/1/12 Ending: 12/31/12

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 75,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 74,420	2
3. Under or (over) accrual (line 2 minus line 1).		$ (580)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 78,141	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.		$ 77,561	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	69,122	8
	2008	72,576	9
	2009	73,734	10
	2010	74,866	11
	2011	74,420	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MORTON TERRACE CARE CTR COUNTY TAZEWELL

FACILITY IDPH LICENSE NUMBER 0045500

CONTACT PERSON REGARDING THIS REPORT PAMELA PHILLIPS

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 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-06-29-115-003	NURSING HOME	$ 74,420.20	$ 74,420.20
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 74,420.20	$ 74,420.20

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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 CTR # 0045500 Report Period Beginning: 1/1/12 Ending: 12/31/12

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 CTR # 0045500 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	$ 80,510	27.5	$ 114,202	$ 33,692	$ 556,740	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ROOFTOP AC UNIT / CONDENSOR FAN			2001	5,040		27.5	183	183	2,061	9
10	ROOF REPAIRS			2001	1,900		27.5	69	69	781	10
11	DRY PIPE VALVE			2001	2,225		27.5	81	81	908	11
12	DOORS, LOCKS, ROOM SIGNS, WALLPAPER			2002	29,163		27.5	1,060	1,060	12,129	12
13	WALLPAPER			2002	67,200		27.5	2,444	2,444	25,749	13
14	ROOFING, PARKING LOT REPAIR			2002	40,373		27.5	1,468	1,468	15,269	14
15	WATER HEATER, AIR COMPRESSOR			2002	15,986		27.5	581	581	5,988	15
16	ROOF TOP AC, CONCRETE WORK, MIXING VALVE, CLOSERS			2003	8,894		27.5	323	323	3,055	16
17	ROOF REPAIR, CONDENSOR, STORAGE			2004	36,866		27.5	1,341	1,341	11,343	17
18	SECURITY, PAGING SYSTEM			2005	9,400		27.5	342	342	2,552	18
19	GUTTERS, EXHAUST FAN			2005	5,632		27.5	205	205	1,528	19
20	PATIO/WALK REPAIR			2005	1,882		15	125	125	938	20
21	CONCRETE WALK W/ REMOVALS , EXIT SIGNS			2006	6,814		15	454	454	2,838	21
22	RE-ROOF-EAST,WEST, NORTH WINGS AND MANSARD			2006	24,500		27.5	891	891	5,754	22
23	INSTALLATION OF A NEW CARRIER FURNACE			2006	7,355		27.5	267	267	1,725	23
24	FLOORING - LOBBY, DINING ROOM			2006	43,890		27.5	1,596	1,596	10,308	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	15,000	26
27											27
28											28
29	SHOWER ROOM			2007	16,990		27.5	618	618	3,038	29
30	C WING TILE-A.M. REMODELING-CONTRACT PMT			2007	20,000		10	2,000	2,000	11,500	30
31	BATHROOM REMODEL-A.M. REMODELING-CNTRACT PMT			2007	26,000		27.5	945	945	5,355	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	4,120	34
35	ROOFTOP UNIT			2007	11,540		10	1,154	1,154	6,443	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 CTR # 0045500 Report Period Beginning: 1/1/12 Ending: 12/31/12

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 PM	2007	$ 26,200	$	27.5	$ 953	$ 953	$ 5,321	37
38	INSTALL DRYER (RECLASS $3,709 TO MME CAP DESK AUI	2007			10				38
39	INSTALL 3 TON SEER A/C (REMOVE $1,750 CAP DESK AUDI	2007			5				39
40	HALL & ROOM VINYL TILES-A.M. REMODELING-CONTRA	2007	56,790		10	5,679	5,679	31,235	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	3,999	42
43	D WING -A.M. REMODELING-CONTRACT PMT	2007	28,040		27.5	1,020	1,020	5,440	43
44	E WING -A.M. REMODELING-CONTRACT PMT	2007	47,790		27.5	1,738	1,738	9,124	44
45	A WING -A.M. REMODELING-CONTRACT PMT	2007	48,540		27.5	1,765	1,765	9,119	45
46	B WING -A.M. REMODELING-CONTRACT PMT	2007	79,540		27.5	2,892	2,892	14,460	46
47	REMODEL HALL, BTY SHOP, OFFICE-CONTRACT PMT	2007	7,960		27.5	289	289	1,541	47
48	REMODEL VARIOUS ROOMS-A.M. REMODELING-CONTRA	2008	5,925		27.5	215	215	1,058	48
49	M WING-A.M. REMODELING-CONTRACT PMT	2008	40,000		27.5	1,455	1,455	6,790	49
50	HOT WATER HEATER	2008	2,025		10	203	203	964	50
51	36 SHADOW BOXES	2008	1,804		27.5	66	66	297	51
52	5 SMOKE DETECTORS/INSTALLATION	2008	1,026		10	103	103	455	52
53	DINING ROOM REMODEL-A.M. REMODELING-CONTRACT	2008	9,995		27.5	363	363	1,603	53
54	CONCRETE RAMP	2008	4,890		15	326	326	1,413	54
55	FIRE WALL EXTENSION-A.M. REMODELING-CONTRACT P	2008	9,885		27.5	359	359	1,496	55
56	SMOKE DETECTORS	2008	2,957		10	296	296	1,209	56
57	FENCE	2008	5,759		15	384	384	1,568	57
58	ASBESTOS INSPECTION	2009	1,882		5	376	376	1,473	58
59	WINDOW REPLACEMENTS	2009	40,500		20	2,025	2,025	7,425	59
60	FIRE ALARM CONTROL PANEL	2009	3,835		10	384	384	1,408	60
61	2 RINNAI WATER HEATERS	2009	12,050		10	1,205	1,205	4,418	61
62	ROOF REPLACEMENT	2009	34,700		10	3,470	3,470	11,567	62
63	NATURAL GAS WATER HEATER	2009	1,157		10	116	116	387	63
64	TANKLESS WATER HEATER	2009	2,850		10	285	285	855	64
65	WINDOW REPLACEMENTS	2009	2,035		20	102	102	306	65
66	THERAPY OFFICE FLOOR COVERING	2009	9,950		10	995	995	2,985	66
67	THERAPY ROOM CABINETS	2009	9,890		15	659	659	1,977	67
68	THERAPY ROOM FLOORING	2009	9,990		10	999	999	2,997	68
69	BATHROOM REMODEL (RMS 2, 4, 6 & 8)-CONTRACT-A.M. F	2009	9,880		27.5	359	359	1,077	69
70	TOTAL (lines 4 thru 69)		$ 4,105,043	$ 80,510		$ 163,384	$ 82,874	$ 839,089	70

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

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

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	$ 80,510		$ 163,384	$ 82,874	$ 839,089	1
2	REMODEL ROOMS 1&2-CONTRACT-A.M. REMODELING	2009	9,420		27.5	343	343	1,029	2
3	REMODEL ROOMS 3&4-CONTRACT-A.M. REMODELING	2009	9,420		27.5	343	343	1,029	3
4	REMODEL ROOMS 5&6-CONTRACT-A.M. REMODELING	2009	9,420		27.5	343	343	1,029	4
5	REMODEL ROOMS 7&8 -CONTRACT-A.M. REMODELING	2009	9,420		27.5	343	343	1,029	5
6	100,000 BTU FURNACE	2009	2,295		10	230	230	690	6
7	TRANSFORMER/MOTHER BOARD ON GENERATOR	2010	2,626		5	525	525	1,269	7
8	INSTALLATION/TESTING NETWORK CABLE	2010	2,635		20	132	132	308	8
9	AUTOMATIC FIRE SPRINKLER	2010	16,740		25	670	670	1,396	9
10	WINDOW REPLACEMENT	2010	14,873		20	744	744	1,612	10
11	WATER HEATERS	2011	3,327		10	333	333	638	11
12	TRENCHING FOR SATTELITE TV	2011	4,824		10	482	482	844	12
13	TV SYSTEM	2011	11,563		10	1,156	1,156	2,023	13
14	KITCHEN WALL-REPAIR & TILE-CONTRACT-A.M. REMOD	2011	3,600		27.5	131	131	207	14
15	FURNACE	2011	4,500		10	450	450	713	15
16	ROOF TOP RHEEM	2011	3,050		10	305	305	483	16
17	PANEL FOR ELECT LOADS	2011	7,298		10	730	730	1,034	17
18	FIRE SPRINKLER	2011	4,740		25	190	190	253	18
19	ROOF	2011	14,390		27.5	523	523	654	19
20	WATER HEATERS	2011	6,650		10	665	665	831	20
21	FOAM CORE MONUMENT SIGN	2011	2,625		10	263	263	307	21
22	SIGN	2012	2,951		10	295	295	295	22
23	REPLACE SPRINKLER HEADS	2012	8,664		25	347	347	347	23
24	CARRIER 6-TON ROOFTOP	2012	6,885		10	516	516	516	24
25	MAGNETIC LOCKS	2012	22,440		10	1,467	1,467	1,467	25
26	A/C SYSTEM	2012	12,630		15	491	491	491	26
27	LIGHT FIXTURES	2012	4,851		10	243	243	243	27
28	RADIATOR	2012	2,887		15	80	80	80	28
29	6 TON ROOF TOP SYSTEM	2012	7,750		10	323	323	323	29
30	A/C SYSTEM	2012	3,710		10	124	124	124	30
31	PIPING REPAIR - M WING, PT, DINING RM	2012	2,814		25	28	28	28	31
32	EMERGENCY FURNACE REPLACE	2012	2,280		10	25	25	25	32
33				42,938			(42,938)		33
34	TOTAL (lines 1 thru 33)		$ 4,326,321	$ 123,448		$ 176,224	$ 52,776	$ 860,406	34

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

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

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,326,321	$ 123,448		$ 176,224	$ 52,776	$ 860,406	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27	ALLOCATION FROM PLATINUM HEALTH CARE			616		616			27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,326,321	$ 124,064		$ 176,840	$ 52,776	$ 860,406	34

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

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

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	$ 2,570,194	$ 24,359	$ 35,157	$ 10,798		$ 2,101,367	71
72	Current Year Purchases	14,962		511	511		511	72
73	Fully Depreciated Assets							73
74	ALLOCATION FROM PLATINUM		2,169	2,169				74
75	TOTALS	$ 2,585,156	$ 26,528	$ 37,837	$ 11,309		$ 2,101,878	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)	$ 7,108,998	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 150,592	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 214,677	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 64,085	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,962,284	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 CTR # 0045500 Report Period Beginning: 1/1/12 Ending: 12/31/12

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.	/2013	$
13.	/2014	$
14.	/2015	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 73,530 Description: Med equip 40,776; Printer/copiers 25,233; VAC Ther Equip 6,053; Postage 832; Drinking water 636
    (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	Business	Ford Bus 2010	$ #######	$ 14,451	17
18	Business	Honda Odyssey 2010	467.00	4,200	18
19	Business	Van Rental		130	19
20					20
21	TOTAL		$ #######	$ 18,781	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 CTR # 0045500 Report Period Beginning: 1/1/12 Ending: 12/31/12

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 CTR # 0045500 Report Period Beginning: 1/1/12 Ending: 12/31/12

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-03	hrs	$	282	$ 18,971	$	282	$ 18,971	1
2	Licensed Speech and Language Development Therapist	10a-03	hrs		29	1,756		29	1,756	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-03	hrs		285	19,357		285	19,357	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				163,279		163,279	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Resp Therp	10a-03				66			66	12
13	Other (specify): Lab & X-ray	39-02					17,169		17,169	13
14	TOTAL			$	596	$ 40,150	$ 180,448	596	$ 220,598	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 CTR # 0045500 Report Period Beginning: 1/1/12 Ending: 12/31/12

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/12 (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	$ 58,794	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,500,056		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	52,929		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,611,779	$	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			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			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)**	$	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,611,779	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 832,852	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	45,435		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	92,650		31
32	Accrued Real Estate Taxes(Sch.IX-B)	78,141		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	74,936		36
37	Due Others	(1,334,614)		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ (210,600)	$	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)**	$ (210,600)	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,822,379	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,611,779	$	48

***(See instructions.)**

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

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,485,022	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)**	$ 3,485,023	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	537,356	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	(1,200,000)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (662,644)	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)**	$ 2,822,379	24	*

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

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

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,821,158	1
2	Discounts and Allowances for all Levels	(282,711)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,538,447	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,919,207	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,919,207	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	5,256	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	240,233	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	15,111	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 260,600	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	366	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 366	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC INCOME	4,739	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,739	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,723,359	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,448,746	31
32	Health Care	3,163,158	32
33	General Administration	1,983,498	33
	B. Capital Expense		
34	Ownership	890,379	34
	C. Ancillary Expense		
35	Special Cost Centers	180,448	35
36	Provider Participation Fee	519,774	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,186,003	40
41	**Income before Income Taxes (line 30 minus line 40)****	537,356	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 537,356	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,891,331	44
45	Private Pay - Net Inpatient Revenue	988,631	45
46	Medicare - Net Inpatient Revenue	597,720	46
47	Other-(specify) Managed Care	(131,440)	47
48	Other-(specify) Part B C/A, Bad Debts, Prior Year Adj	182,715	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,528,957	49

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

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	2,055	2,251	$ 81,810	$ 36.34	1
2	Assistant Director of Nursing	1,796	1,869	51,807	27.72	2
3	Registered Nurses	10,246	10,925	254,542	23.30	3
4	Licensed Practical Nurses	33,762	35,417	823,515	23.25	4
5	CNAs & Orderlies	78,300	81,670	925,235	11.33	5
6	CNA Trainees					6
7	Licensed Therapist	5,076	5,781	179,419	31.04	7
8	Rehab/Therapy Aides	10,049	11,440	318,063	27.80	8
9	Activity Director	3,855	4,249	61,445	14.46	9
10	Activity Assistants	11,081	11,575	111,744	9.65	10
11	Social Service Workers	3,656	3,830	66,457	17.35	11
12	Dietician					12
13	Food Service Supervisor	3,055	3,146	41,724	13.26	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,556	20,470	194,206	9.49	15
16	Dishwashers					16
17	Maintenance Workers	4,404	4,590	60,304	13.14	17
18	Housekeepers	20,306	21,303	206,987	9.72	18
19	Laundry	7,125	7,690	76,081	9.89	19
20	Administrator	1,920	2,081	106,781	51.31	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,643	14,687	214,111	14.58	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	1,774	1,951	33,909	17.38	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	231,659	244,925	$ 3,808,140 *	$ 15.55	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	174	$ 9,586	1.3	35
36	Medical Director	Monthly	6,000	9.3	36
37	Medical Records Consultant	Quarterly	1,880	10.3	37
38	Nurse Consultant			10.3	38
39	Pharmacist Consultant		15,405	10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	203	11,806	11.3	44
45	Social Service Consultant	56	3,416	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	433	$ 48,093		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 CTR # 0045500 Report Period Beginning: 1/1/12 Ending: 12/31/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
WILLIAM WADE	ADMINISTRATOR		$ 106,781
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 106,781

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		$ 278,125
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 278,125

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 164,161
Unemployment Compensation Insurance	159,729
FICA Taxes	307,066
Employee Health Insurance	88,832
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K	1,136
EMPLOYEE BENEFITS - OTHER	11,865
EMPLOYEE PHYSICAL EXAM	16,474
TOTAL (agree to Schedule V, line 22, col.8)	$ 749,263

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	14,391
Health Care Worker Background Check	1,920
(Indicate # of checks performed)	
Patient Background Checks	
ADVERTISING & MARKETING	19,513
DUES & SUBSCRIPTIONS	10,213
LICENSES	3,751
ALLOCATION FROM PLATINUM	514
Less: Public Relations Expense	( )
Non-allowable advertising	(19,513)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 30,789

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,866
ALLOCATION FROM PLATINUM	373
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,239

* Attach copy of IMRF notifications

**See instructions.

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

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

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 $15,234

(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?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 yrs

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 2,181 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. $ 519,774
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. $ N/A Has any meal income been offset against related costs? N/A Indicate the amount. $ N/A

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $ N/A
c. What percent of all travel expense relates to transportation of nurses and patients?
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?
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period. $

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

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

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