FOR BHF USE

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

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: 0045518

Facility Name: MORTON VILLA CARE CTR

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

County: TAZEWELL

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

HFS ID Number:

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

Type of Ownership:

	VOLUNTARY,NON-PROFIT		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 VILLA CARE CTR # 0045518 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	106	Skilled (SNF)	106	38,796	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	106	TOTALS	106	38,796	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	17,602		3,802	21,404	8
9	SNF/PED					9
10	ICF		3,742		3,742	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,602	3,742	3,802	25,146	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.82%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 7/17/2001

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 106 and days of care provided 3,169

Medicare Intermediary CGS

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 VILLA CARE CTR # 0045518 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	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	196,737	19,026	10,302	226,065		226,065		226,065			1
2	Food Purchase		226,848		226,848		226,848	(17)	226,831			2
3	Housekeeping	113,710	17,509		131,219		131,219		131,219			3
4	Laundry	65,982	15,612		81,594		81,594		81,594			4
5	Heat and Other Utilities			124,497	124,497		124,497	1,220	125,717			5
6	Maintenance	44,818	456	61,195	106,469		106,469	1,837	108,306			6
7	Other (specify):*											7
8	TOTAL General Services	421,247	279,451	195,994	896,692		896,692	3,040	899,732			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,384,691	89,938	14,334	1,488,963		1,488,963		1,488,963			10
10a	Therapy	276,375	143	116,665	393,183		393,183		393,183			10a
11	Activities	56,990	5,813	7,629	70,432		70,432		70,432			11
12	Social Services	37,709		3,904	41,613		41,613		41,613			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,755,765	95,894	148,532	2,000,191		2,000,191		2,000,191			16
	C. General Administration											
17	Administrative	85,584		121,050	206,634		206,634	(113,283)	93,351			17
18	Directors Fees											18
19	Professional Services			260,540	260,540		260,540	715	261,255			19
20	Dues, Fees, Subscriptions & Promotions			32,757	32,757		32,757	(12,495)	20,262			20
21	Clerical & General Office Expenses	194,938	26,960	68,508	290,406		290,406	21,604	312,010			21
22	Employee Benefits & Payroll Taxes			425,254	425,254		425,254		425,254			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,993	6,993		6,993	217	7,210			24
25	Other Admin. Staff Transportation			28,330	28,330		28,330	1,631	29,961			25
26	Insurance-Prop.Liab.Malpractice			98,122	98,122		98,122	316	98,438			26
27	Other (specify):*							8,634	8,634			27
28	TOTAL General Administration	280,522	26,960	1,041,554	1,349,036		1,349,036	(92,661)	1,256,375			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,457,534	402,305	1,386,080	4,245,919		4,245,919	(89,621)	4,156,298			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number MORTON VILLA CARE CTR #0045518 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			23,686	23,686		23,686	147,223	170,909			30
31	Amortization of Pre-Op. & Org.							58	58			31
32	Interest			45,260	45,260		45,260	188,555	233,815			32
33	Real Estate Taxes			43,000	43,000		43,000	482	43,482			33
34	Rent-Facility & Grounds			463,648	463,648		463,648	(463,498)	150			34
35	Rent-Equipment & Vehicles			46,086	46,086		46,086	513	46,599			35
36	Other (specify):*											36
37	**TOTAL Ownership**			621,680	621,680		621,680	(126,667)	495,013			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			128,564	128,564		128,564		128,564			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			298,214	298,214		298,214		298,214			42
43	Other (specify):*							(352)	(352)			43
44	**TOTAL Special Cost Centers**			426,778	426,778		426,778	(352)	426,426			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,457,534	402,305	2,434,538	5,294,377		5,294,377	(216,640)	5,077,737			45

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

Facility Name & ID Number MORTON VILLA CARE CTR # 0045518 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				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	(136)	32		10
11	Discounts, Allowances, Rebates & Refunds	(50)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(17)	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	(9,685)	21		18
19	Entertainment				19
20	Contributions	(2,435)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers		19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(8,874)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,477)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	38,490			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 15,816		$	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)	(232,456)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (232,456)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (216,640)		37

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

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

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

MORTON VILLA CARE CTR

ID# 0045518

Report Period Beginning: 1/1/12

Ending: 12/31/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	IL COUNCIL LTC - COPE	$ (3,919)	20	1
2	MISC INCOME	(328)	21	2
3	TAXES-GENERAL	(289)	21	3
4	MARKETING SALARIES	(300)	43	4
5	MARKETING EMPLOYEE BENEFITS	(52)	43	5
6	ADJ TO S/L DEPR	43,378	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**	38,490		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MORTON VILLA CARE CTR # 0045518 **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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(17)	0	0	0	0	0	0	0	0	0	0	(17)	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	1,220	0	0	0	0	0	0	0	0	1,220	5
6	Maintenance	0	0	1,837	0	0	0	0	0	0	0	0	1,837	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(17)	0	3,057	0	0	0	0	0	0	0	0	3,040	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	(113,283)	0	0	0	0	0	0	0	0	(113,283)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(3,255)	3,970	0	0	0	0	0	0	0	0	715	19
20	Fees, Subscriptions & Promotions	(12,793)	0	298	0	0	0	0	0	0	0	0	(12,495)	20
21	Clerical & General Office Expenses	(14,264)	0	35,868	0	0	0	0	0	0	0	0	21,604	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	217	0	0	0	0	0	0	0	0	217	24
25	Other Admin. Staff Transportation	0	0	1,631	0	0	0	0	0	0	0	0	1,631	25
26	Insurance-Prop.Liab.Malpractice	0	0	316	0	0	0	0	0	0	0	0	316	26
27	Other (specify):*	0	0	8,634	0	0	0	0	0	0	0	0	8,634	27
28	**TOTAL General Administration**	(27,057)	(3,255)	(62,349)	0	0	0	0	0	0	0	0	(92,661)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(27,074)	(3,255)	(59,292)	0	0	0	0	0	0	0	0	(89,621)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MORTON VILLA CARE CTR # 0045518 **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 D. Ownership	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)	
30	Depreciation	43,378	102,228	1,617	0	0	0	0	0	0	0	0	147,223	30
31	Amortization of Pre-Op. & Org.	0	0	58	0	0	0	0	0	0	0	0	58	31
32	Interest	(136)	187,864	827	0	0	0	0	0	0	0	0	188,555	32
33	Real Estate Taxes	0	0	482	0	0	0	0	0	0	0	0	482	33
34	Rent-Facility & Grounds	0	(463,648)	150	0	0	0	0	0	0	0	0	(463,498)	34
35	Rent-Equipment & Vehicles	0	0	513	0	0	0	0	0	0	0	0	513	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	43,242	(173,556)	3,647	0	0	0	0	0	0	0	0	(126,667)	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):*	(352)	0	0	0	0	0	0	0	0	0	0	(352)	43
44	**TOTAL Special Cost Centers**	(352)	0	0	0	0	0	0	0	0	0	0	(352)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	15,816	(176,811)	(55,645)	0	0	0	0	0	0	0	0	(216,640)	45

Facility Name & ID Number MORTON VILLA CARE CTR # 0045518 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	$ 463,648	MORTON VILLA REALTY, LLC		$	$ (463,648)	1
2	V	30	DEPRECIATION				102,228	102,228	2
3	V	32	INTEREST				185,001	185,001	3
4	V	32	AMORTIZATION-LOAN COSTS				2,863	2,863	4
5	V								5
6	V								6
7	V								7
8	V	19	PROFESSIONAL FEES	133,200	PHC CONSULTANTS, LLC		129,945	(3,255)	8
9	V								9
10	V	19	PROFESSIONAL FEES	2,461	MTS CONSULTING		2,461		10
11	V								11
12	V								12
13	V								13
14	Total			$ 599,309			$ 422,498	$ * (176,811)	14

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

Facility Name & ID Number MORTON VILLA CARE CTR # 0045518 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	$ 121,050	PLATINUM HEALTH CARE, LLC	100.00%	$	$ (121,050)	15
16	V	5	Utilities		PLATINUM HEALTH CARE, LLC		1,220	1,220	16
17	V	6	Repairs & Maintenance		PLATINUM HEALTH CARE, LLC		1,837	1,837	17
18	V	17	Administrative Salary		PLATINUM HEALTH CARE, LLC		7,767	7,767	18
19	V	19	Professional Fees		PLATINUM HEALTH CARE, LLC		3,970	3,970	19
20	V	20	Fees, Subscriptions		PLATINUM HEALTH CARE, LLC		298	298	20
21	V	21	Clerical Salaries		PLATINUM HEALTH CARE, LLC		32,831	32,831	21
22	V	21	Office Expenses		PLATINUM HEALTH CARE, LLC		3,037	3,037	22
23	V	24	Education & Seminars		PLATINUM HEALTH CARE, LLC		217	217	23
24	V	25	Travel		PLATINUM HEALTH CARE, LLC		1,631	1,631	24
25	V	26	Insurance		PLATINUM HEALTH CARE, LLC		316	316	25
26	V	27	Employee Benefits		PLATINUM HEALTH CARE, LLC		8,634	8,634	26
27	V	30	Depreciation		PLATINUM HEALTH CARE, LLC		1,116	1,116	27
28	V	35	Equipment Rental		PLATINUM HEALTH CARE, LLC		513	513	28
29	V	31	Amortization		PLATINUM HEALTH CARE, LLC		58	58	29
30	V	30	Depreciation		PLATINUM HEALTH CARE, LLC		501	501	30
31	V	32	Interest		PLATINUM HEALTH CARE, LLC		827	827	31
32	V	33	Real Estate Taxes		PLATINUM HEALTH CARE, LLC		482	482	32
33	V	34	Office Rent		PLATINUM HEALTH CARE, LLC		150	150	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 121,050			$ 65,405	$ * (55,645)	39

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

Facility Name & ID Number MORTON VILLA CARE CTR # 0045518 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	BRIAN LEVINSON	21.667	BELLA VISTA CARE CENTER	PEORIA HEIGHTS	CARE, LLC			2
3	MARK SHAPIRO	21.667	CAPITOL CARE CENTER	SPRINGFIELD	MORTON VILLA REALTY, LLC		BUILDING	3
4	ABM LIMITED PARTNERSHIP	1.11	COLONIAL HALL CARE CENTER	PRINCETON	PHC CONSULTANTS	SKOKIE	CONSULTING	4
5	ABRAHAM STERN	4.44	MORTON TERRACE 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 VILLA CARE CTR # 0045518 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	Owner	Administrative	21.68	SEE ATTACHED	2	3.85	Mgt Fees	$		1
2	BRIAN LEVINSON	Owner	Administrative	21.67	SEE ATTACHED	4	10.00	Mgt Fees			2
3	MARK SHAPIRO	Owner	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 VILLA CARE CTR # 0045518 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	$	25,146	$ 1,220	1
2	6	Repairs & Maintenance	Patient Days	923,219	30	67,446		25,146	1,837	2
3	17	Administrative Salary	Patient Days	923,219	30	285,177	285,177	25,146	7,767	3
4	19	Professional Fees	Patient Days	923,219	30	145,744		25,146	3,970	4
5	20	Fees, Subscriptions	Patient Days	923,219	30	10,954		25,146	298	5
6	21	Clerical Salaries	Patient Days	923,219	30	1,205,375	1,205,375	25,146	32,831	6
7	21	Office Expenses	Patient Days	923,219	30	111,487		25,146	3,037	7
8	24	Education & Seminars	Patient Days	923,219	30	7,956		25,146	217	8
9	25	Travel	Patient Days	923,219	30	59,896		25,146	1,631	9
10	26	Insurance	Patient Days	923,219	30	11,602		25,146	316	10
11	27	Employee Benefits	Patient Days	923,219	30	316,988		25,146	8,634	11
12	30	Depreciation	Patient Days	923,219	30	40,988		25,146	1,116	12
13	35	Equipment Rental	Patient Days	923,219	30	18,824		25,146	513	13
14	31	Amortization	Patient Days	923,219	30	2,134		25,146	58	14
15	30	Depreciation	Patient Days	923,219	30	18,405		25,146	501	15
16	32	Interest	Patient Days	923,219	30	30,356		25,146	827	16
17	33	Real Estate Taxes	Patient Days	923,219	30	17,678		25,146	482	17
18	34	Office Rent	Patient Days	923,219	30	5,488		25,146	150	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,401,289	$ 1,490,552		$ 65,405	25

Facility Name & ID Number MORTON VILLA CARE CTR # 0045518 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	CAPMARK		X	MORTGAGE	$32,733.40	2/28/06	$ 3,414,100	$ 3,190,175	2/28/41	5.3500	$ 185,001	1
2			X	LOAN COSTS	W/O OVER LOAN						2,863	2
3												3
4												4
5												5
	Working Capital											
6	HFG		X	LINE OF CREDIT							45,260	6
7												7
8												8
9	TOTAL Facility Related				$32,733.40		$ 3,414,100	$ 3,190,175			$ 233,124	9
	B. Non-Facility Related*											
10	INTEREST INCOME OFFSET										(136)	10
11												11
12												12
13	ALLOCATION FROM PLATINUM										827	13
14	TOTAL Non-Facility Related						$	$			$ 691	14
15	TOTALS (line 9+line14)						$ 3,414,100	$ 3,190,175			$ 233,815	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 15,662 Line # 32

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number MORTON VILLA CARE CTR # 0045518 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.**	$	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.)		$ 39,122	2
3. Under or (over) accrual (line 2 minus line 1).		$ 39,122	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$	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.		$ 39,122	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	36,337	8
	2008	38,152	9
	2009	38,761	10
	2010	39,356	11
	2011	39,122	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 VILLA CARE CTR COUNTY TAZEWELL

FACILITY IDPH LICENSE NUMBER 0045518

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.	06-06-29-301-010	NURSING HOME	$ 39,121.54	$ 39,121.54
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 39,121.54	$ 39,121.54

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			$ 159,149	1
2					2
3	TOTALS			$ 159,149	3

Facility Name & ID Number MORTON VILLA CARE CTR # 0045518 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		$ 2,399,586	$ 61,526	27.5	$ 87,258	$ 25,732	$ 555,394	4
5					132,495		27.5	4,818	4,818	24,090	5
6											6
7											7
8											8
	Improvement Type**										
9	MIXING VALVES / REGULATOR BOARD			2001	1,701		27.5	62	62	734	9
10	WINDOWS			2001	1,528		27.5	56	56	718	10
11	PATIO REPAIR			2001	3,550		27.5	129	129	1,575	11
12	EMPLOYEE DOOR KEYPADS			2002	4,303		27.5	156	156	1,690	12
13	ROOF REPAIR			2002	3,620		27.5	132	132	1,489	13
14	PARKING BLOCKS			2002	9,000		27.5	327	327	3,726	14
15	PAINTING/WALLPAPER (REMOVED $8,299 CAP DESK AUDIT 2008			2002	7,615		27.5	277	277	2,769	15
16	HEATING & AIR			2002	2,022		27.5	74	74	813	16
17	HEATING & AIR			2003	4,581		27.5	167	167	1,576	17
18	STEEL COUNTER FIRE DOOR			2003	1,862		27.5	68	68	753	18
19	WATER HEATER			2004	4,918		27.5	179	179	1,514	19
20	CARPET, TILE, BLINDS, TOILETS			2005	5,438		27.5	198	198	1,476	20
21	AIR CONDITIONER (REMOVED $950 CAP DESK AUDIT 2008)			2005			27.5				21
22	SPRINKLERS			2006	3,840		27.5	140	140	904	22
23	INSTALLED NEW DRIP-EDGE AND GAF ROOF			2006	4,862		27.5	177	177	1,143	23
24	FLOORING IN FRONT LOBBY AND FRONT HALLWAYS			2006	36,410		27.5	1,324	1,324	8,551	24
25	AIR CONDITIONER (REMOVED $2,145 CAP DESK AUDIT 2008)			2006			27.5				25
26	LANDSCAPING			2006	10,000		15	667	667	4,335	26
27	INSTALLATION OF IRRIGATION SYSTEM			2006	10,300		27.5	375	375	2,421	27
28	SHOWER ROOMS			2007	55,000		27.5	2,000	2,000	11,833	28
29	CALL CORDS-12 ROOMS(REMOVED $1,319 CAP DESK AUDIT 2008			2007			10				29
30	FURNITURE			2007							30
31	ADDL SHOWER ROOM WORK			2007	3,600		27.5	131	131	753	31
32	INSTALL & PROV OF EXHAUST			2007	3,825		27.5	139	139	799	32
33	16 CHESTS			2007							33
34	DRAPERY PANELS			2007	2,794		7	399	399	2,195	34
35	PARKING LOT PAVEMENT & PATCH			2007	3,725		20	186	186	1,023	35
36	REMDL BRKRM-A.M. REMODELING & DEC-CONTRACT PM			2007	8,660		27.5	315	315	1,680	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number MORTON VILLA CARE CTR # 0045518 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	INSPECT & REPAIR ROOF	2007	$ 20,000	$	27.5	$ 727	$ 727	$ 3,907	37
38	CHECK & REPAIR PLUMBING	2007	20,000		27.5	727	727	3,877	38
39	RHEEM 5 TON ROOFTOP UNIT	2007	5,950		27.5	216	216	1,134	39
40	PTAC UNITS	2007	1,830		27.5	67	67	346	40
41	PTAC UNITS	2007	1,600		27.5	58	58	300	41
42	SIDEWALKS	2007	10,000		20	500	500	2,500	42
43	A&B WING HALLWAYS/RES. RMS-A.M. REMODELING-CON	2008	50,000		30	1,667	1,667	8,057	43
44	2 PTAC UNITS	2008	1,800		10	180	180	870	44
45	AIR CONDITIONER UNITS	2008	2,379		10	238	238	1,150	45
46	B WING -A.M. REMODELING-CONTRACT PMT	2008	10,000		30	333	333	1,582	46
47	A WING BACK HALL VINYL TILE-A.M. REMODELING-CON	2008	14,500		10	1,450	1,450	6,888	47
48	A WING DRYWALL -A.M. REMODELING-CONTRACT PMT	2008	15,845		30	528	528	2,508	48
49	B WING LONG/ BACK HALLS-VINYL TILE-A.M. REMODEL-	2008	17,850		10	1,785	1,785	8,479	49
50	B WING BACK HALL DRYWALL-A.M. REMODELING-CONT	2008	2,500		30	83	83	395	50
51	A WING LONG HALL -A.M. REMODELING-CONTRACT PMT	2008	10,000		30	333	333	1,582	51
52	M WING -A.M. REMODELING-CONTRACT PMT	2008	11,970		30	399	399	1,829	52
53	A WING ROOMS -A.M. REMODELING-CONTRACT PMT	2008	8,960		30	299	299	1,345	53
54	M WING HALLWAY -A.M. REMODELING-CONTRACT PMT	2008	37,025		30	1,234	1,234	5,553	54
55	NEW SIDEWALK - JACKSON & SONS CONCRETE	2008	4,890		15	326	326	1,386	55
56	FRONT OFFICE -A.M. REMODELING-CONTRACT PMT	2008	9,965		30	332	332	1,439	56
57	A&B WING HALLWAY -A.M. REMODELING-CONTRACT PM	2008	9,700		30	323	323	1,400	57
58	ENTRYWAY -A.M. REMODELING-CONTRACT PMT	2008	9,975		30	333	333	1,443	58
59	A WING HALLWAY VINYL FLOOR	2008	9,625		10	963	963	4,173	59
60	2 HEATING/ AC UNITS (REMOVED $1,672 CAP DESK AUDIT	2008			5				60
61	A WING HALLWAY-A.M. REMODELING-CONTRACT PMT	2008	29,800		30	993	993	4,220	61
62	A WING HALL VINYL FLOOR-A.M. REMODELING-CONTR I	2008	16,450		5	3,290	3,290	13,708	62
63	B WING HALL VINYL FLOOR-A.M. REMODELING-CONTR I	2008	6,895		5	1,379	1,379	5,746	63
64	LOBBY & TV ROOM FURNITURE (REMOVED $1,016 CAP DE	2008			15				64
65	B WING LONG HALL VINYL FLOOR-A.M. REMODEL-CONT	2008	9,702		10	970	970	3,961	65
66	B WING HALL -A.M. REMODELING-CONTRACT PMT	2008	25,803		30	860	860	3,512	66
67	VINYL FLOOR- 6 PATIENT ROOMS-A.M. REMODEL-CONTR	2008	10,848		10	1,085	1,085	4,430	67
68	6 PATIENT ROOMS -A.M. REMODELING-CONTRACT PMT	2008	19,110		30	637	637	2,601	68
69	ROOM 16 VINYL FLOORING -A.M. REMODELING-CONTR P	2008	1,808		10	181	181	739	69
70	TOTAL (lines 4 thru 69)		$ 3,132,015	$ 61,526		$ 122,250	$ 60,724	$ 735,014	70

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

Facility Name & ID Number MORTON VILLA CARE CTR # 0045518 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	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,132,015	$ 61,526		$ 122,250	$ 60,724	$ 735,014	1
2	ROOM 16 REMODEL -A.M. REMODELING-CONTRACT PMT	2008	3,185		30	106	106	433	2
3	ROOM 21 VINYL FLOOR -A.M. REM (REMOVED $1,808 CAP	2008			10				3
4	ROOM 21 REMODEL -A.M. REMODELING-CONTRACT PMT	2008	3,185		30	106	106	424	4
5	ROOM 37 & 39 VINYL FLOOR-A.M. REMODELING-CONTR F	2008	3,616		10	362	362	1,448	5
6	ROOM 37 & 39 -A.M. REMODELING-CONTRACT PMT	2008	6,370		30	212	212	848	6
7	ROOM 40 & 43 VINYL FLOOR-A.M. REMODELING-CONTR F	2008	3,616		10	362	362	1,448	7
8	ROOM 40 & 43 -A.M. REMODELING-CONTRACT PMT	2008	6,370		30	212	212	848	8
9	2 HEATING/ AC UNITS	2008	1,672		5	334	334	1,336	9
10	10 PHOTOELECTRIC SMOKE DET (REMOVED 2,472 CAP DE	2008			10				10
11	ROOM 46 & 53 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	212	212	848	11
12	ROOM 51 & 55 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	212	212	848	12
13	BATHROOM 1-11-16-21 REMODEL-CONTRACT PMT-A.M. RI	2009	9,480		30	316	316	1,264	13
14	ROOM 47 & 49 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	212	212	848	14
15	2 HEATING AIR UNITS (REMOVD $1,720 PER 2010 CAP COST	2009			5				15
16	ROOM 4 & 5 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	212	212	848	16
17	BATHROOM 23-26-37-39 REMODEL-CONTRACT PMT-A.M. F	2009	9,480		30	316	316	1,238	17
18	ROOM 30 & 32 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	212	212	831	18
19	ROOM 6 & 33 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	212	212	831	19
20	BATHROOM 27-29-40-43 REMODEL-CONTRACT PMT-A.M. F	2009	9,480		30	316	316	1,238	20
21	ASBESTOS INSPECTION (REMOVED $1,882 PER 2010 CAP C	2009			10				21
22	ROOM 34 & 35 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	212	212	831	22
23	BATHROOM 46-51-53-55 REMODEL-CONTRACT PMT-A.M. F	2009	9,480		30	316	316	1,238	23
24	ROOM 42 & 44 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	212	212	831	24
25	BATHROOM 30-32-47-49 REMODEL-CONTRACT PMT-A.M. F	2009	9,480		30	316	316	1,211	25
26	ROOM 36 & 38 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	212	212	813	26
27	ROOM 48 &52 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	212	212	813	27
28	BATHROOM 4-5-6-33 REMODEL-CONTRACT PMT-A.M. REM	2009	9,480		30	316	316	1,211	28
29	ROOM 41 & 24 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	212	212	795	29
30	BATHROOM 34-35-42-44 REMODEL-CONTRACT PMT-A.M. F	2009	6,370		30	212	212	795	30
31	ROOM 22 & 25 REMODEL-CONTRACT-A.M. REMODELING (	2009			30				31
32	BATHROOM 36-38-48-52 REMODEL-CONTRACT PMT-A.M. F	2009	9,480		30	316	316	1,185	32
33	BATHROOM 45-14-56-12 REMODEL-CONTRACT PMT-A.M. F	2009	9,480		30	316	316	1,185	33
34	TOTAL (lines 1 thru 33)		$ 3,312,309	$ 61,526		$ 129,016	$ 67,490	$ 761,501	34

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

Facility Name & ID Number MORTON VILLA CARE CTR # 0045518 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		$ 3,312,309	$ 61,526		$ 129,016	$ 67,490	$ 761,501	1
2	BATHROOM 22-24-25-41 REMODEL-CONTRACT PMT-A.M. R	2009	9,480		30	316	316	1,185	2
3	ROOM 45 & 14 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	212	212	795	3
4	CONSTR ON BACK PATIO-SLAB-JACKER CONSTRUCTION	2009			30				4
5	ROOM 56 & 12 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	212	212	778	5
6	BATHROOM 7-18-28 REMODEL-CONTRACT PMT-A.M. REM	2009	7,110		30	237	237	869	6
7	3 HEAT/AIR UNITS & 1 AIR/HEAT SLEEVE UNIT	2009	2,624		5	525	525	1,881	7
8	ROOM 7 REMODEL-CONTRACT-A.M. REMODELING	2009	3,185		30	106	106	380	8
9	BATHROOM 2-3-15-19 REMODEL-CONTRACT PMT-A.M. RE	2009	9,480		30	316	316	1,132	9
10	ROOM 28 & 18 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	212	212	760	10
11	BATHROOM 9-10-50-54 REMODEL-CONTRACT PMT-A.M. RI	2009	9,480		30	316	316	1,132	11
12	RELOCATE WALK IN COOLER CONDENSOR UNIT (REMOV	2009			5				12
13	ROOM 2 & 3 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	212	212	742	13
14	RAISE SLAB E & SE CORNER OF BLDG-SLAB-JACKER CON	2009			20				14
15	ROOM 15 & 19 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	212	212	742	15
16	ADD'L SLABS RAISED-SLAB-JACKER CONSTRUCTION (RE	2009			20				16
17	ROOF REPAIR-MARK'S CONSTRUCTION ENTERPRISE	2009	29,900		27.5	1,087	1,087	3,714	17
18	ROOM 50 & 54 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	212	212	724	18
19									19
20	ROOM 9 & 10 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	212	212	724	20
21	WINDOW REPLACEMENT-AMERICAN SIDING (REMOVED	2009			30				21
22	ROOM 13 & 17 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	212	212	707	22
23	THERAPY RM/FRONT OFFICE-REPAIR WATER DAMAAGE	2009	9,325		27.5	339	339	1,130	23
24	WINDOW REPLACEMENT-CONTRACT-A.M. REMODELING	2009	17,600		30	587	587	1,883	24
25	2 HEATING AIR UNITS (REMOVED $1,760 PER 2010 CAP COS	2009			5				25
26	33 NEW REPLACEMENT WINDOWS-A.M. REMODELING	2009	4,125		30	138	138	425	26
27	ROOM 8 REMODEL-CONTRACT-A.M. REMODELING	2009	4,993		30	166	166	512	27
28	BATHROOM 8-13-17 REMODEL-CONTRACT PMT-A.M. REM	2009	7,100		30	237	237	731	28
29	VINYL FLOOR ROOM 46,53,51,55-CONTRACT-A.M. REMODE	2009	7,232		10	723	723	2,892	29
30	VINYL FLOOR ROOM 47,49-CONTRACT-A.M. REMODELINC	2009	3,616		10	362	362	1,448	30
31	VINYL FLOOR ROOM 4,5-CONTRACT-A.M. REMODELING	2009	3,616		10	362	362	1,448	31
32	VINYL FLOOR ROOM 30,32-CONTRACT-A.M. REMODELINC	2009	3,616		10	362	362	1,417	32
33	VINYL FLOOR ROOM 6,33-CONTRACT-A.M. REMODELING	2009	3,616		10	362	362	1,417	33
34	TOTAL (lines 1 thru 33)		$ 3,499,367	$ 61,526		$ 137,253	$ 75,727	$ 791,069	34

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

Facility Name & ID Number MORTON VILLA CARE CTR # 0045518 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 12C, Carried Forward		$ 3,499,367	$ 61,526		$ 137,253	$ 75,727	$ 791,069	1
2	VINYL FLOOR ROOM 34,35-CONTRACT-A.M. REMODELINC	2009	3,616		10	362	362	1,417	2
3	VINYL FLOOR ROOM 42,44-CONTRACT-A.M. REMODELINC	2009	3,616		10	362	362	1,417	3
4	VINYL FLOOR ROOM 36,28-CONTRACT-A.M. REMODELINC	2009	3,616		10	362	362	1,387	4
5	VINYL FLOOR ROOM 48,52-CONTRACT-A.M. REMODELINC	2009	3,616		10	362	362	1,387	5
6	VINYL FLOOR ROOM 41,24-CONTRACT-A.M. REMODELINC	2009	3,616		10	362	362	1,357	6
7	VINYL FLOOR ROOM 34,3542,44-CONTRACT-A.M. REMODE	2009	3,616		10	362	362	1,357	7
8	VINYL FLOOR ROOM 45,14-CONTRACT-A.M. REMODELINC	2009	3,616		10	362	362	1,357	8
9	VINYL FLOOR ROOM 56,12-CONTRACT-A.M. REMODELINC	2009	3,616		10	362	362	1,327	9
10	VINYL FLOOR ROOM 2,3-CONTRACT-A.M. REMODELING	2009	3,616		10	362	362	1,267	10
11	VINYL FLOOR ROOM 15,16-CONTRACT-A.M. REMODELINC	2009	3,616		10	362	362	1,267	11
12	VINYL FLOOR ROOM 50,54-CONTRACT-A.M. REMODELINC	2009	3,616		10	362	362	1,237	12
13	VINYL FLOOR ROOM 9,10-CONTRACT-A.M. REMODELING	2009	3,616		10	362	362	1,237	13
14	VINYL FLOOR ROOM 13,17-CONTRACT-A.M. REMODELINC	2009	3,616		10	362	362	1,207	14
15	VINYL FLOOR ROOM 7-CONTRACT-A.M. REMODELING	2009	1,808		10	181	181	648	15
16	VINYL FLOOR ROOM 28,18-CONTRACT-A.M. REMODELINC	2009	3,616		10	362	362	1,297	16
17	4 HEATING/AIR UNITS	2010	3,445		5	689	689	2,067	17
18	PIPED NEW RUN OF SPRINKLER	2010	3,420		25	137	137	388	18
19	SPRINKLER COVERAGE FOR ATTIC	2010	8,963		25	359	359	1,017	19
20	FIRE ALARM SYSTEM CONTROL	2010	4,729		10	473	473	1,301	20
21	BEDROOM REMODEL-ROOM #20	2010	4,993		30	166	166	401	21
22	RHEEM RTU	2010	4,385		15	292	292	584	22
23	WATER HEATER	2011	9,735		10	974	974	1,866	23
24	COAX CABLE INSTALL	2011	4,824		10	482	482	844	24
25	TV CABLE INSTALL	2011	11,563		10	1,156	1,156	2,023	25
26	HVAC INSTALL	2011	6,167		15	411	411	480	26
27	WATER HEATER	2011	5,620		10	562	562	984	27
28	SIGN	2012	2,950		10	295	295	295	28
29				23,275			(23,275)		29
30				28,888			(28,888)		30
31									31
32	ALLOCATION FROM PLATINUM			357		357			32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,622,593	$ 114,046		$ 148,855	$ 34,809	$ 822,485	34

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

Facility Name & ID Number MORTON VILLA CARE CTR # 0045518 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	$ 850,369	$ 12,225	$ 20,220	$ 7,995		$ 754,092	71
72	Current Year Purchases	10,222		574	574		574	72
73	Fully Depreciated Assets							73
74	ALLOCATION FROM PLATINUM		1,260	1,260				74
75	TOTALS	$ 860,591	$ 13,485	$ 22,054	$ 8,569		$ 754,666	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)	$ 4,642,333	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 127,531	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 170,909	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 43,378	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,577,151	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number MORTON VILLA CARE CTR # 0045518 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: $ 45,957 Description: Med equip $39,929; Printer/copiers $5,180; Postage Meter $848
    (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			$ Misc	$ 129	17
18					18
19					19
20					20
21	TOTAL		$	$ 129	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number MORTON VILLA CARE CTR # 0045518 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 VILLA CARE CTR # 0045518 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	$	779	$ 44,138	$	779	$ 44,138	1
2	Licensed Speech and Language Development Therapist	10a-03	hrs		41	2,528		41	2,528	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-03	hrs		1,029	69,999		1,029	69,999	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				116,403		116,403	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					12,161		12,161	13
14	TOTAL			$	1,849	$ 116,665	$ 128,564	1,849	$ 245,229	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 VILLA CARE CTR # 0045518 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	$ 74,251	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,458,669		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	40,116		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)**	$ 1,573,036	$	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)**	$ 1,573,036	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 469,819	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,110,012		29
30	Accrued Salaries Payable	45,205		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	67,163		36
37	Due Others	(782,616)		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 909,583	$	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)**	$ 909,583	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 663,453	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,573,036	$	48

***(See instructions.)**

Facility Name & ID Number MORTON VILLA CARE CTR # 0045518 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**	$ (674,345)	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)**	$ (674,346)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	137,799	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe) DUE MORTON TERRACE ADJ	1,200,000	15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,337,799	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)**	$ 663,453	24	*

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

Facility Name & ID Number MORTON VILLA CARE CTR # 0045518 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	$ 3,687,294	1
2	Discounts and Allowances for all Levels	195,142	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,882,436	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,362,877	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,362,877	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	179,237	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,752	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)**	$ 186,349	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	136	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 136	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC INCOME, DISCOUNTS	378	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 378	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,432,176	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	896,692	31
32	Health Care	2,000,191	32
33	General Administration	1,349,036	33
	B. Capital Expense		
34	Ownership	621,680	34
	C. Ancillary Expense		
35	Special Cost Centers	128,564	35
36	Provider Participation Fee	298,214	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,294,377	40
41	**Income before Income Taxes (line 30 minus line 40)****	137,799	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 137,799	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,663,789	44
45	Private Pay - Net Inpatient Revenue	603,670	45
46	Medicare - Net Inpatient Revenue	421,379	46
47	Other-(specify) Managed Care	(38,837)	47
48	Other-(specify) Part B C/A, Bad Debts, Prior Yr Adj.	232,435	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,882,436	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 VILLA CARE CTR # 0045518 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	2,107	2,261	$ 79,844	$ 35.31	1
2	Assistant Director of Nursing	1,983	2,069	58,702	28.37	2
3	Registered Nurses	4,834	4,962	152,714	30.78	3
4	Licensed Practical Nurses	17,393	18,556	440,465	23.74	4
5	CNAs & Orderlies	54,420	56,774	616,485	10.86	5
6	CNA Trainees					6
7	Licensed Therapist	1,097	1,097	62,690	57.15	7
8	Rehab/Therapy Aides	6,527	7,302	213,685	29.26	8
9	Activity Director	1,712	1,895	25,831	13.63	9
10	Activity Assistants	3,470	3,601	31,159	8.65	10
11	Social Service Workers	2,250	2,501	37,709	15.08	11
12	Dietician					12
13	Food Service Supervisor	6,299	6,846	101,728	14.86	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,826	10,306	95,009	9.22	15
16	Dishwashers					16
17	Maintenance Workers	2,116	2,270	44,818	19.74	17
18	Housekeepers	11,092	11,919	113,710	9.54	18
19	Laundry	6,768	7,276	65,982	9.07	19
20	Administrator	1,928	2,140	85,584	39.99	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,368	12,257	194,938	15.90	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	2,545	2,840	36,481	12.85	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	147,735	156,872	$ 2,457,534 *	$ 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	107	$ 5,871	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		12,454	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	45	2,316	11.3	44
45	Social Service Consultant	67	3,904	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	219	$ 32,425		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number MORTON VILLA CARE CTR # 0045518 Report Period Beginning: 1/1/12 Ending: 12/31/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
CLINTON DAVID MCDANIEL	ADMINISTRATOR		$ 85,584
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 85,584

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		$ 260,540
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 260,540

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 93,510
Unemployment Compensation Insurance	84,074
FICA Taxes	188,396
Employee Health Insurance	43,669
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K	674
EMPLOYEE BENEFITS - OTHER	4,370
EMPLOYEE PHYSICAL EXAM	10,561
TOTAL (agree to Schedule V, line 22, col.8)	$ 425,254

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	10,642
Health Care Worker Background Check	1,178
(Indicate # of checks performed 17)	
Patient Background Checks 90	
ADVERTISING & MARKETING	8,874
DUES & SUBSCRIPTIONS	7,104
LICENSES	1,040
ALLOCATION FROM PLATINUM	298
Less: Public Relations Expense	( )
Non-allowable advertising	(8,874)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,262

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	6,993
ALLOCATION FROM PLATINUM	217
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,210

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MORTON VILLA CARE CTR # 0045518 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 VILLA CARE CTR # 0045518 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 $9,728**

(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?

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,084** 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. $ **298,214**
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.