FOR BHF USE

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

I. IDPH License ID Number: 0052142

Facility Name: Morton Terrace Healthcare And Rehabilitation Centre, Llc

Address: 191 East Queenwood Road (Number) Morton (City) 61550 (Zip Code)

County: Tazewell

Telephone Number: (309) 266-5331 **Fax #** (309) 266-9376

HFS ID Number:

Date of Initial License for Current Owners: 1/1/2013

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda **Telephone Number:** (847) 282-6300
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 01/01/16 to 12/31/16 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)
** Subject to the attached Accountants Consulting Report*
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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 Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 N/A

	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	46	Skilled (SNF)	46	16,836	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	166	TOTALS	166	60,756	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	8,991		3,011	12,002	8
9	SNF/PED					9
10	ICF	13,377	3,649	1,571	18,597	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,368	3,649	4,582	30,599	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 50.36%

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 01/01/2013

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/18/2001 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 46 and days of care provided 1,789

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: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Morton Terrace Healthcare And Rehabilitati # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	200,016	25,589	9,935	235,540		235,540	40	235,580			1
2	Food Purchase		202,166		202,166		202,166	(241)	201,925			2
3	Housekeeping		5,534	212,403	217,937		217,937	522	218,459			3
4	Laundry		2,935	140,581	143,516		143,516		143,516			4
5	Heat and Other Utilities			168,400	168,400		168,400	(10,415)	157,985			5
6	Maintenance	35,866	13,673	84,504	134,043		134,043	(749)	133,294			6
7	Other (specify):*											7
8	**TOTAL General Services**	235,882	249,897	615,823	1,101,602		1,101,602	(10,844)	1,090,758			8
	B. Health Care and Programs											
9	Medical Director			13,000	13,000		13,000		13,000			9
10	Nursing and Medical Records	2,241,428	140,717	69,175	2,451,320		2,451,320	6,888	2,458,208			10
10a	Therapy	3,623			3,623		3,623		3,623			10a
11	Activities	154,008	7,803	75	161,886		161,886		161,886			11
12	Social Services	91,831		910	92,741		92,741	3,461	96,202			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							7,914	7,914			15
16	**TOTAL Health Care and Programs**	2,490,890	148,520	83,160	2,722,570		2,722,570	18,263	2,740,833			16
	C. General Administration											
17	Administrative	97,518		47,837	145,355		145,355	(11,429)	133,926			17
18	Directors Fees											18
19	Professional Services			299,142	299,142		299,142	(209,898)	89,244			19
20	Dues, Fees, Subscriptions & Promotions			65,004	65,004		65,004	(34,375)	30,629			20
21	Clerical & General Office Expenses	178,167	20,949	636,947	836,063		836,063	(466,243)	369,820			21
22	Employee Benefits & Payroll Taxes			452,182	452,182		452,182		452,182			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,990	1,990		1,990	587	2,577			24
25	Other Admin. Staff Transportation			15,952	15,952		15,952	2,640	18,592			25
26	Insurance-Prop.Liab.Malpractice			90,977	90,977		90,977	569	91,546			26
27	Other (specify):*							27,240	27,240			27
28	**TOTAL General Administration**	275,685	20,949	1,610,031	1,906,665		1,906,665	(690,908)	1,215,757			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,002,457	419,366	2,309,014	5,730,837		5,730,837	(683,489)	5,047,348			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 Healthcare And Rehabilitation Centre, Llc #0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			44,220	44,220		44,220	233,551	277,771			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							48	48			32
33	Real Estate Taxes			78,053	78,053		78,053	2,945	80,998			33
34	Rent-Facility & Grounds			296,010	296,010		296,010	(294,642)	1,368			34
35	Rent-Equipment & Vehicles			17,141	17,141		17,141	323	17,464			35
36	Other (specify):*											36
37	**TOTAL Ownership**			435,424	435,424		435,424	(57,776)	377,648			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		99,714	767,507	867,221		867,221		867,221			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			295,001	295,001		295,001		295,001			42
43	Other (specify):*	4,845		29,880	34,725		34,725	(34,725)	0			43
44	**TOTAL Special Cost Centers**	4,845	99,714	1,092,388	1,196,947		1,196,947	(34,725)	1,162,222			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,007,302	519,080	3,836,826	7,363,208		7,363,208	(775,989)	6,587,219			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 Healthcare And Rehabilitation Centre, L # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	(11,521)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	232,045	30		9
10	Interest and Other Investment Income	(2,702)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(241)	02		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	(30,902)	21		18
19	Entertainment				19
20	Contributions	(200)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(474,118)	21		24
25	Fund Raising, Advertising and Promotional	(29,136)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(430,418)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (747,193)		$	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)	(28,796)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (28,796)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (775,989)		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

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Morton Terrace Healthcare And Rehabilitation Centre, Llc

ID# **0052142**

Report Period Beginning: **01/01/16**

Ending: **12/31/16**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Expenses	$ (34,725)	43	1
2	Bank Charges	(6,812)	21	2
3	Theft and Loss	(16)	21	3
4	Sequestration	(21,927)	21	4
5	Miscellaneous Income	(2,437)	21	5
6	Out of Period Expense	(1,500)	21	6
7	Capitalized R&M	(2,592)	06	7
8	Non-Allowable Legal	(11,255)	19	8
9	PAC Dues	(5,308)	20	9
10	Rent for Sale Leaseback Arrangement	(296,010)	34	10
11	Non-Allowable Expense	(47,837)	17	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**	(430,418)		49

Morton Terrace Healthcare And Rehabilitation Centre, Llc

ID# 0052142

Report Period Beginning: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Morton Terrace Healthcare And Rehabilitation Centre, Llc # 0052142 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary			40									40	1
2	Food Purchase	(241)											(241)	2
3	Housekeeping			522									522	3
4	Laundry													4
5	Heat and Other Utilities	(11,521)		915	191								(10,415)	5
6	Maintenance	(2,592)		1,151	509	183							(749)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(14,354)		2,628	700	183							(10,844)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			6,888									6,888	10
10a	Therapy													10a
11	Activities													11
12	Social Services			3,461									3,461	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			7,914									7,914	15
16	**TOTAL Health Care and Programs**			18,263									18,263	16
	C. General Administration													
17	Administrative	(47,837)		36,408									(11,429)	17
18	Directors Fees													18
19	Professional Services	(11,255)		(87,488)	73	(111,229)							(209,898)	19
20	Fees, Subscriptions & Promotions	(34,644)		251	19								(34,375)	20
21	Clerical & General Office Expenses	(537,712)		29,677	13	41,779							(466,243)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			119		469							587	24
25	Other Admin. Staff Transportation			355		2,285							2,640	25
26	Insurance-Prop.Liab.Malpractice			288	123	159							569	26
27	Other (specify):*			20,224		7,016							27,240	27
28	**TOTAL General Administration**	(631,448)		(167)	227	(59,521)							(690,908)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(645,802)		20,724	927	(59,338)							(683,489)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Morton Terrace Healthcare And Rehabilitation Centre, Llc** **#** **0052142** **Report Period Beginning:** **01/01/16** **Ending:** **12/31/16**

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	**232,045**			**1,506**								**233,551**	**30**
31	Amortization of Pre-Op. & Org.													**31**
32	Interest	**(2,702)**			**2,750**								**48**	**32**
33	Real Estate Taxes				**2,945**								**2,945**	**33**
34	Rent-Facility & Grounds	**(296,010)**		**9,927**	**(9,927)**	**1,368**							**(294,642)**	**34**
35	Rent-Equipment & Vehicles			**323**									**323**	**35**
36	Other (specify):*													**36**
37	**TOTAL Ownership**	**(66,667)**		**10,250**	**(2,727)**	**1,368**							**(57,776)**	**37**
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													**38**
39	Ancillary Service Centers													**39**
40	Barber and Beauty Shops													**40**
41	Coffee and Gift Shops													**41**
42	Provider Participation Fee													**42**
43	Other (specify):*	**(34,725)**											**(34,725)**	**43**
44	**TOTAL Special Cost Centers**	**(34,725)**											**(34,725)**	**44**
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	**(747,193)**		**30,974**	**(1,800)**	**(57,970)**							**(775,989)**	**45**

Facility Name & ID Number Morton Terrace Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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. [ ] YES [X] 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			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number Morton Terrace Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	1	DIETARY	$	MOSAIC HEALTHCARE	100.00%	$ 40	$ 40	15
16	V	3	HOUSEKEEPING		MOSAIC HEALTHCARE	100.00%	522	522	16
17	V	5	UTILITIES		MOSAIC HEALTHCARE	100.00%	915	915	17
18	V	6	REPAIRS AND MAINT.		MOSAIC HEALTHCARE	100.00%	1,151	1,151	18
19	V	10	NURSING SALARIES		MOSAIC HEALTHCARE	100.00%	36,768	36,768	19
20	V	12	SOCIAL SERVICE SALARIES		MOSAIC HEALTHCARE	100.00%	3,461	3,461	20
21	V	15	NURSING EMP BENS & PR TAXES		MOSAIC HEALTHCARE	100.00%	7,914	7,914	21
22	V	17	ADMINISTRATIVE SALARIES		MOSAIC HEALTHCARE	100.00%	36,408	36,408	22
23	V	19	PROFESSIONAL FEES		MOSAIC HEALTHCARE	100.00%	1,127	1,127	23
24	V	20	FEES, SUBSCRIPTIONS		MOSAIC HEALTHCARE	100.00%	251	251	24
25	V	21	CLERICAL AND GENERAL SALARIES		MOSAIC HEALTHCARE	100.00%	66,398	66,398	25
26	V	21	CLERICAL AND GENERAL EXP		MOSAIC HEALTHCARE	100.00%	8,159	8,159	26
27	V	24	SEMINARS		MOSAIC HEALTHCARE	100.00%	119	119	27
28	V	25	ADMIN. STAFF TRANS.		MOSAIC HEALTHCARE	100.00%	355	355	28
29	V	26	INSURANCE		MOSAIC HEALTHCARE	100.00%	288	288	29
30	V	27	GEN. ADMIN. EMP. BEN.		MOSAIC HEALTHCARE	100.00%	20,224	20,224	30
31	V	34	RENT - BUILDING (RELATED)		MOSAIC HEALTHCARE	100.00%	9,927	9,927	31
32	V	35	EQUIPMENT RENTAL		MOSAIC HEALTHCARE	100.00%	323	323	32
33	V								33
34	V	19	BOOKKEEPING	58,735	MOSAIC HEALTHCARE	100.00%		(58,735)	34
35	V	19	ADMINISTRATIVE CONSULTANT	29,880	MOSAIC HEALTHCARE	100.00%		(29,880)	35
36	V	10	MDS CONSULTANT	29,880	MOSAIC HEALTHCARE	100.00%		(29,880)	36
37	V	21	OFFICE CONSULTANT	44,880	MOSAIC HEALTHCARE	100.00%		(44,880)	37
38	V								38
39	Total			$ 163,375			$ 194,349	$ * 30,974	39

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

Facility Name & ID Number Morton Terrace Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	5	UTILITIES		4600 TOUHY, LLC	100.00%	191	$ 191	15
16	V	6	REPAIRS & MAINT.		4600 TOUHY, LLC	100.00%	509	509	16
17	V	19	PROFESSIONAL FEES		4600 TOUHY, LLC	100.00%	73	73	17
18	V	20	FEES, SUBSCRIPTIONS		4600 TOUHY, LLC	100.00%	19	19	18
19	V	21	CLERICAL & GENERAL		4600 TOUHY, LLC	100.00%	13	13	19
20	V	26	INSURANCE		4600 TOUHY, LLC	100.00%	123	123	20
21	V	30	DEPRECIATION		4600 TOUHY, LLC	100.00%	1,506	1,506	21
22	V	32	INTEREST EXPENSE		4600 TOUHY, LLC	100.00%	2,750	2,750	22
23	V	33	REAL ESTATE TAXES		4600 TOUHY, LLC	100.00%	2,945	2,945	23
24	V								24
25	V	34	RENT	9,927	4600 TOUHY, LLC	100.00%		(9,927)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 9,927			$ 8,127	$ * (1,800)	39

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

Facility Name & ID Number Morton Terrace Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	6	MAINTENANCE & REPAIR	$	PLATINUM BILLING SOLUTIONS	30.00%	$ 183	$ 183	15
16	V	19	PROFESSIONAL SERVICES		PLATINUM BILLING SOLUTIONS	30.00%	966	966	16
17	V	21	CLERICAL & GENERAL		PLATINUM BILLING SOLUTIONS	30.00%	6,466	6,466	17
18	V	21	CLERICAL & GENERAL- SALARY		PLATINUM BILLING SOLUTIONS	30.00%	35,314	35,314	18
19	V	24	BUSINESS SEMINAR		PLATINUM BILLING SOLUTIONS	30.00%	469	469	19
20	V	25	AUTO & TRAVEL		PLATINUM BILLING SOLUTIONS	30.00%	2,285	2,285	20
21	V	26	INSURANCE		PLATINUM BILLING SOLUTIONS	30.00%	159	159	21
22	V	27	EMPLOYEE BENEFITS/TAXES		PLATINUM BILLING SOLUTIONS	30.00%	7,016	7,016	22
23	V	34	RENT		PLATINUM BILLING SOLUTIONS	30.00%	1,368	1,368	23
24	V								24
25	V	19	AR MANAGEMENT SERVICES	112,195	PLATINUM BILLING SOLUTIONS	30.00%		(112,195)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 112,195			$ 54,225	$ * (57,970)	39

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

Facility Name & ID Number Morton Terrace Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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. ☐ 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Morton Terrace Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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. ☐ 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Morton Terrace Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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. ☐ 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Morton Terrace Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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. ☐ 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Morton Terrace Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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. ☐ 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Morton Terrace Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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. ☐ 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Morton Terrace Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	CENTRAL ILLINOIS OPERATIONS LLC	99.99%	MOSAIC OF BEACON	CHICAGO	4600 Touhy LLC	LINCOLNWOOD	BUILDING CO.	1
2	MORTON TERRACE HEALTH AND REHAB CENTER	0.01%	MOSAIC OF LAKE SHORE	CHICAGO	MOSAIC HC	LINCOLNWOOD	BOOKKEEPING	2
3			MOSAIC OF MAYFIELD	CHICAGO	TETRAD MANAGEMENT, LLC	LINCOLNWOOD	MANAGEMENT CO.	3
4			MOSAIC OF SPRINGFIELD	SPRINGFIELD, IL	PLATINUM BILLING SOLUTION	LAKEWOOD, NJ	BILLING SERVICES	4
5			COLONIAL HEALTHCARE & REHABILITATION CENTRE	PRINCETON, IL	Worthy Insurance Group, LLC	Skokie	Insurance Company	5
6			THE HEIGHTS HEALTHCARE & REHABILITATION CENTRE	PEORIA HEIGHTS, IL				6
7			MORTON VILLA HEALTHCARE & REHABILTATION CENTRE	MORTON, IL				7
8			MOSAIC OF UPTOWN	CHICAGO				8
9			RIVERSHORES HEALTHCARE & REHABILTATION CENTRE	MASEILLES, IL				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 Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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								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								27
28								28
29								29
30								30

Facility Name & ID Number Morton Terrace Healthcare And Rehabilitat # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	N/A								$		1
2											2
3											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 Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 [ ] NO [X]

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$	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	TOTALS					$	$		$	25

Facility Name & ID Number Morton Terrace Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: MOSAIC HEALTHCARE
Street Address: 4600 W. TOUHY AVENUE, SUITE 200
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	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	1	DIETARY	PATIENT DAYS	483,176	10	$ 625	$	30,599	$ 40	1
2	3	HOUSEKEEPING	PATIENT DAYS	483,176	10	8,235		30,599	522	2
3	5	UTILITIES	PATIENT DAYS	483,176	10	14,454		30,599	915	3
4	6	REPAIRS AND MAINT.	PATIENT DAYS	483,176	10	18,179		30,599	1,151	4
5	10	NURSING SALARIES	PATIENT DAYS	483,176	10	580,592	580,592	30,599	36,768	5
6	12	SOCIAL SERVICE SALARIES	PATIENT DAYS	483,176	10	54,655	54,655	30,599	3,461	6
7	15	NURSING EMP BENS & PR TAX	PATIENT DAYS	483,176	10	124,964		30,599	7,914	7
8	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	483,176	10	574,906	574,906	30,599	36,408	8
9	19	PROFESSIONAL FEES	PATIENT DAYS	483,176	10	17,800		30,599	1,127	9
10	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	483,176	10	3,962		30,599	251	10
11	21	CLERICAL AND GENERAL SAI	PATIENT DAYS	483,176	10	1,048,463	1,048,463	30,599	66,398	11
12	21	CLERICAL AND GENERAL EX	PATIENT DAYS	483,176	10	128,829		30,599	8,159	12
13	24	SEMINARS	PATIENT DAYS	483,176	10	1,876		30,599	119	13
14	25	ADMIN. STAFF TRANS.	PATIENT DAYS	483,176	10	5,603		30,599	355	14
15	26	INSURANCE	PATIENT DAYS	483,176	10	4,543		30,599	288	15
16	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	483,176	10	319,345		30,599	20,224	16
17	34	RENT - BUILDING (RELATED)	PATIENT DAYS	483,176	10	156,750		30,599	9,927	17
18	35	EQUIPMENT RENTAL	PATIENT DAYS	483,176	10	5,104		30,599	323	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,068,885	$ 2,258,616		$ 194,349	25

Facility Name & ID Number Morton Terrace Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: 4600 TOUHY, LLC
Street Address: 4600 W. TOUHY AVENUE, SUITE 200
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: ((773) 463-1313
Fax Number: ((773) 463- 5311

	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	MNGCR. PATIENT DAYS	483,176	10	3,010		30,599	191	1
2	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS	483,176	10	8,036		30,599	509	2
3	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS	483,176	10	1,150		30,599	73	3
4	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS	483,176	10	293		30,599	19	4
5	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS	483,176	10	209		30,599	13	5
6	26	INSURANCE	MNGCR. PATIENT DAYS	483,176	10	1,941		30,599	123	6
7	30	DEPRECIATION	MNGCR. PATIENT DAYS	483,176	10	23,779		30,599	1,506	7
8	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS	483,176	10	43,419		30,599	2,750	8
9	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS	483,176	10	46,499		30,599	2,945	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	TOTALS					$ 128,334	$		$ 8,127	25

Facility Name & ID Number Morton Terrace Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 BILLING SOLUTIONS
Street Address: 1100 TOWBIN AVENUE, UNIT C
City / State / Zip Code: LAKEWOOD, NJ 08701
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	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	6	MAINTENANCE & REPAIR	PATIENT DAYS	483,176	10	$ 2,885	$	30,599	$ 183	1
2	19	PROFESSIONAL SERVICES	PATIENT DAYS	483,176	10	15,260		30,599	966	2
3	21	CLERICAL & GENERAL	PATIENT DAYS	483,176	10	102,097		30,599	6,466	3
4	21	CLERICAL & GENERAL- SALA	PATIENT DAYS	483,176	10	557,621	557,621	30,599	35,314	4
5	24	BUSINESS SEMINAR	PATIENT DAYS	483,176	10	7,400		30,599	469	5
6	25	AUTO & TRAVEL	PATIENT DAYS	483,176	10	36,080		30,599	2,285	6
7	26	INSURANCE	PATIENT DAYS	483,176	10	2,507		30,599	159	7
8	27	EMPLOYEE BENEFITS/TAXES	PATIENT DAYS	483,176	10	110,789		30,599	7,016	8
9	34	RENT	PATIENT DAYS	483,176	10	21,600		30,599	1,368	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	TOTALS					$ 856,240	$ 557,621		$ 54,225	25

Facility Name & ID Number Morton Terrace Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 ☐ NO ☐

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$	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	TOTALS					$	$		$	25

Facility Name & ID Number Morton Terrace Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 ☐ NO ☐

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$	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	TOTALS					$	$		$	25

Facility Name & ID Number Morton Terrace Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 ☐ NO ☐

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$	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	TOTALS					$	$		$	25

Facility Name & ID Number Morton Terrace Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 ☐ NO ☐

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$	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	TOTALS					$	$		$	25

Facility Name & ID Number Morton Terrace Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 ☐ NO ☐

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$	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	TOTALS					$	$		$	25

Facility Name & ID Number Morton Terrace Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 ☐ NO ☐

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$	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	TOTALS					$	$		$	25

Facility Name & ID Number Morton Terrace Healthcare And Rehabilitati # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5					-							5
	Working Capital											
6	Allocated from 4600 Touhy	X									2,750	6
7												7
8					-							8
9	TOTAL Facility Related						$	$			$ 2,750	9
	B. Non-Facility Related*											
10	Interest Income		X								(2,702)	10
11												11
12												12
13					-							13
14	TOTAL Non-Facility Related						$	$			$ (2,702)	14
15	TOTALS (line 9+line14)						$	$			$ 48	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

*** 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 Healthcare And Rehabilitatic # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

** 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 Healthcare And Rehabilitation Centre, Llc # 0052142 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	77,497	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.)	$	85,320	2
3. Under or (over) accrual (line 2 minus line 1).	$	7,823	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$	73,175	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.	$	80,998	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2011		8
2012	80,587	9
2013	80,277	10
2014	81,094	11
2015	82,375	12

2016 Accrual: $82,375 x 0.89 = $73,175 (Rounded)

Allocated from 4600 Touhy LLC: $2,945

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Morton Terrace Healthcare And Rehabilitation Centre, Llc COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0052142

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-06-29-115-003	Long Term Care Property	$ 82,375.26	$ 82,375.26
2.	See Attached	Home Office Allocation	$ 89,919.35	$ 2,847.25
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 172,294.61	$ 85,222.51

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? X YES _____ 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Morton Terrace Healthcare And Rehabilitation Centre, Llc COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0052142

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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 _____ 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 [ ] (b) Rent from a Related Organization. [X] (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 [X] (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).

None

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2013	$ 469,511	1
2	Allocated from 4600 Touhy LLC			5,700	2
3	TOTALS			$ 475,211	3

Facility Name & ID Number Morton Terrace Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	166		2013	1971	$ 3,724,471	$	39	$ 95,499	$ 95,499	$ 381,996	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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

*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 Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		66,394	1,506		2,777	1,271	13,555	68
69	Financial Statement Depreciation			44,220			(44,220)		69
70	TOTAL (lines 4 thru 69)		$ 3,790,865	$ 45,726		$ 98,276	$ 52,550	$ 395,551	70

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

Facility Name & ID Number Morton Terrace Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 3,790,865	$ 45,726		$ 98,276	$ 52,550	$ 395,551	1
2	Walk-In Cooler	2013	2,868		20	191	191	701	2
3	Water Heater	2013	4,950		20	495	495	1,774	3
4	A/C Unit - Rheem Rknl060	2013	6,482		20	1,296	1,296	4,537	4
5	A/C Unit - Rheem Condenser	2013	3,555		20	711	711	2,370	5
6	Installation Of Tankless Hot Water Heater	2013	4,950		20	248	248	887	6
7	Water Heater	2013	2,785		20	139	139	429	7
8	Air Compressor	2014	3,950		20	790	790	2,107	8
9	Landscaping & Fence Repairs	2014	5,500		20	275	275	688	9
10	Install New Condensor	2014	2,945		20	147	147	356	10
11	Installed 2 Furnaces	2014	13,905		20	695	695	1,854	11
12	C Wing Furnace Replacement	2014	3,150		20	158	158	354	12
13	Install 2 Furnaces & More Coil	2014	16,500		20	825	825	2,338	13
14	Keypad Door Alarm	2015	2,980		20	149	149	186	14
15	Heather Replacement	2015	3,100		20	155	155	168	15
16	Repair Leak In Laundry Room / Rebuild Supply Maulford - Wate	2015	2,880		20	144	144	228	16
17	Install New 4" Pipe For Fire System Leaking In Dining Room Are	2015	2,538		20	127	127	169	17
18	Repaired Leaking Pipe	2016	2,592		20	130	130	130	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	TOTAL (lines 1 thru 33)		$ 3,876,495	$ 45,726		$ 104,951	$ 59,225	$ 414,827	34

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

Facility Name & ID Number Morton Terrace Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 3,876,495	$ 45,726		$ 104,951	$ 59,225	$ 414,827	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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,876,495	$ 45,726		$ 104,951	$ 59,225	$ 414,827	34

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

Facility Name & ID Number Morton Terrace Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 3,876,495	$ 45,726		$ 104,951	$ 59,225	$ 414,827	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
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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	TOTAL (lines 1 thru 33)		$ 3,876,495	$ 45,726		$ 104,951	$ 59,225	$ 414,827	34

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

Facility Name & ID Number Morton Terrace Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 12D, Carried Forward		$ 3,876,495	$ 45,726		$ 104,951	$ 59,225	$ 414,827	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
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16									16
17									17
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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	TOTAL (lines 1 thru 33)		$ 3,876,495	$ 45,726		$ 104,951	$ 59,225	$ 414,827	34

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

Facility Name & ID Number Morton Terrace Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Morton Terrace Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 12F, Carried Forward		$	$		$	$	$	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
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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	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Morton Terrace Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from 4600 Touhy LLC	2012	32,517	834	30	1,084	250	5,419	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Mosaic Healthcare	2013	546		20	27	27	109	9
10	Allocated from Mosaic Healthcare	2012	6,789		20	339	339	1,697	10
11									11
12	Allocated from 4600 Touhy LLC	2012	20,941	539	20	1,047	508	5,235	12
13	Allocated from 4600 Touhy LLC	2013	5,095	120	20	255	135	1,019	13
14	Allocated from 4600 Touhy LLC	2014	506	13	20	25	12	76	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	TOTAL (lines 1 thru 33)		$ 66,394	$ 1,506		$ 2,777	$ 1,271	$ 13,555	34

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

Facility Name & ID Number Morton Terrace Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 12H, Carried Forward		$ 66,394	$ 1,506		$ 2,777	$ 1,271	$ 13,555	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 66,394	$ 1,506		$ 2,777	$ 1,271	$ 13,555	34

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

Facility Name & ID Number Morton Terrace Healthcare And Rehabilitation Cen # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 1,630,555	$	$ 172,820	$ 172,820	10	$ 450,878	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	16,264				10	16,264	73
74								74
75	TOTALS	$ 1,646,819	$	$ 172,820	$ 172,820		$ 467,142	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		Allocated from Mosaic HC	2016	$ 6,016	$	$	$	5	$ 6,016	76
77										77
78										78
79										79
80	TOTALS			$ 6,016	$	$	$		$ 6,016	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,004,542	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 45,726	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 277,771	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 232,045	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 887,984	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 Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: ARC Healthcare II Operating Partnership (Sale Leaseback Arrangement)
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. [X] 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:		166		$ 296,010			3
4	Additions							4
5					(296,010)			5
6	Allocated from Platinum Billing Solutions				1,368			6
7	TOTAL		166		$ 1,368 **			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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 1,391 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2014 Ford Challenger	$	$ 16,073	17
18					18
19					19
20					20
21	TOTAL		$ -	$ 16,073	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 Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 329,097	$		$ 329,097	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			37,995			37,995	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			208,240			208,240	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				85,453		85,453	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					192,175	14,261		206,436	13
14	TOTAL			$		$ 767,507	$ 99,714		$ 867,221	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Morton Terrace Healthcare And Rehabilitation Centre, Llc # 0052142 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/16 **(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	$ 107,331	$	1
2	Cash-Patient Deposits	22,452		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,313,674		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	32,115		6
7	Other Prepaid Expenses	5,131		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	559,212		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,039,915	$	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	65,258		15
16	Equipment, at Historical Cost	190,364		16
17	Accumulated Depreciation (book methods)	(129,614)		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): See Attached Schedule	543,405		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 669,413	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,709,328	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,840,419	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	22,452		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	86,387		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,159		31
32	Accrued Real Estate Taxes(Sch.IX-B)	73,175		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	126,190		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,154,782	$	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	See Attached Schedule	2,462,170		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,462,170	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,616,952	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,907,624)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,709,328	$	48

***(See instructions.)**

Facility Name & ID Number Morton Terrace Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (878,185)	1
2	Restatements (describe):		2
3	PY Depreciation	(2,215)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (880,400)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,027,224)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,027,224)	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)**	$ (1,907,624)	24 *

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

Facility Name & ID Number Morton Terrace Healthcare And Rehabilitation Cer # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 6,629,878	1
2	Discounts and Allowances for all Levels	(1,248,322)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,381,556	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	869,666	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 869,666	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	71,594	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,886	19
20	Radiology and X-Ray	705	20
21	Other Medical Services	1,438	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 79,623	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,702	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,702	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	2,437	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,437	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,335,984	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,101,602	31
32	Health Care	2,722,570	32
33	General Administration	1,906,665	33
	B. Capital Expense		
34	Ownership	435,424	34
	C. Ancillary Expense		
35	Special Cost Centers	901,946	35
36	Provider Participation Fee	295,001	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,363,208	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,027,224)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,027,224)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,771,665	44
45	Private Pay - Net Inpatient Revenue	911,024	45
46	Medicare - Net Inpatient Revenue	523,975	46
47	Other-(specify) Hospice, Managed Care Medicare	1,159,417	47
48	Other-(specify) Insurance	15,475	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,381,556	49

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **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 Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,874	2,037	$ 82,629	$ 40.56	1
2	Assistant Director of Nursing	1,887	2,051	70,281	34.27	2
3	Registered Nurses	17,324	18,830	518,541	27.54	3
4	Licensed Practical Nurses	20,106	21,855	582,003	26.63	4
5	CNAs & Orderlies	68,760	74,740	936,932	12.54	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	155	169	3,623	21.44	8
9	Activity Director	1,663	1,808	26,537	14.68	9
10	Activity Assistants	9,914	10,776	127,471	11.83	10
11	Social Service Workers	3,359	3,651	72,423	19.84	11
12	Dietician					12
13	Food Service Supervisor	2,491	2,708	30,409	11.23	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,368	19,965	169,607	8.50	15
16	Dishwashers					16
17	Maintenance Workers	2,064	2,244	35,866	15.98	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,000	2,197	97,518	44.39	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,046	2,224	47,219	21.23	23
24	Clerical	8,448	9,183	130,948	14.26	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	2,389	2,597	51,042	19.65	31
32	Other Health Care(specify)					32
33	Other(specify)	1,689	1,837	24,252	13.20	33
34	TOTAL (lines 1 - 33)	164,537	178,872	$ 3,007,301 *	$ 16.81	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	Monthly	$ 9,935	01-03	35
36	Medical Director	Monthly	13,000	09-03	36
37	Medical Records Consultant	Monthly	2,040	10-03	37
38	Nurse Consultant	Monthly	29,880	10-03	38
39	Pharmacist Consultant	Monthly	7,375	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	75	11-03	44
45	Social Service Consultant	14	910	12-03	45
46	Other(specify) MDS Consultant	Monthly	29,880	10-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)	14	$ 93,095		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 Healthcare And Rehabilitation Centı # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Nicole Hibbard	Administrator	0.00%	$ 54,741
Robin Lemasters	Administrator	0.00%	18,200
Jerlene Jamison	Administrator	0.00%	24,577
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 97,518

B. Administrative - Other

Description	Amount
Management Fees - Tetrad Management	$ 47,837
TOTAL (agree to Schedule V, line 17, col. 3)	$ 47,837
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 19,347
Madison Specs	Cost Segregation	1,608
Prospect Resources	Energy Procurement	36
Ability Network	Data Processing	4,966
Creative Technology	Data Processing	2,747
Provinet Solutions	Data Processing	1,391
Sikich LLP	Data Processing	4,286
Health MedX LLC	Data Processing	26,042
Galaxy Software	Data Processing	1,460
SmartLinx	Data Processing	5,851
Compu-Solutions	Data Processing	4,590
See Supplemental Schedule		226,818
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 299,142

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 126,335
Unemployment Compensation Insurance	69,949
FICA Taxes	221,460
Employee Health Insurance	29,042
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K Match	1,418
Holiday Expense	350
Other Employee Benefits	3,628
TOTAL (agree to Schedule V, line 22, col.8)	$ 452,182

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	10,023
Health Care Worker Background Check	1,802
(Indicate # of checks performed 163.8)	
Patient Background Checks	
Dues and Subscriptions	14,184
License and Permits	4,351
Allocated from Mosaic HC	251
Allocated from 4600 Touhy LLC	19
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 30,630

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,990
Allocated from Mosaic HC	119
Allocated from Platinum Billing Solutions	469
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,578

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Morton Terrace Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on Long Term Care $16,085**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **28,668** Line **10**

(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? **Yes**
If YES, give effective date of lease. **12/31/2014**

(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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **295,001**
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. $ 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? **100% Ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees