

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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.

<p>I. IDPH Facility ID Number: <u>0045500</u></p> <p>Facility Name: <u>MORTON TERRACE CARE CENTER</u></p> <p>Address: <u>191 EAST QUEENWOOD ROAD</u> <u>MORTON</u> <u>61550</u> Number City Zip Code</p> <p>County: <u>TAZEWELL</u></p> <p>Telephone Number: <u>(309) 866-5331</u> Fax # <u>(309) 866-9376</u></p> <p>HFS ID Number: <u>36-4438626</u></p> <p>Date of Initial License for Current Owners: <u>08/01</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2006</u> to <u>12/31/2006</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="3" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>BENJAMIN M. KLEIN</u></td> </tr> <tr> <td>(Title) <u>MANAGER</u></td> </tr> </table> <table border="1"> <tr> <td rowspan="4" style="width: 15%;">Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u></td> </tr> <tr> <td>(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> </tr> </table> <p>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></p> <p>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</p>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>BENJAMIN M. KLEIN</u>	(Title) <u>MANAGER</u>	Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>	(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>
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Facility Name & ID Number MORTON TERRACE CARE CENTER

0045500 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	44	Skilled (SNF)	44	16,060	1
2		Skilled Pediatric (SNF/PED)			2
3	120	Intermediate (ICF)	120	43,800	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	164	TOTALS	164	59,860	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	39,823		5,422	45,245	8
9	SNF/PED					9
10	ICF		6,189		6,189	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,823	6,189	5,422	51,434	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.92%

D. How many bed-hold days during this year were paid by the Department? 0 (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)

NONE

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

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

I. On what date did you start providing long term care at this location?
Date started 07/18/01

J. Was the facility purchased or leased after January 1, 1978?
YES Date 07/18/01 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 48 and days of care provided 4,700

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number **MORTON TERRACE CARE CENTER** # **0045500** Report Period Beginning: **01/01/2006** Ending: **12/31/2006**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	216,022	19,515	10,611	246,148		246,148	0	246,148		1
2	Food Purchase		249,348		249,348	0	249,348	(4,174)	245,174		2
3	Housekeeping	152,093	33,496	0	185,589		185,589	0	185,589		3
4	Laundry	90,187	9,520	0	99,707	0	99,707	0	99,707		4
5	Heat and Other Utilities			145,495	145,495		145,495	5,761	151,256		5
6	Maintenance	34,783	63,845	5,110	103,738		103,738	6,014	109,752		6
7	Other (specify):*			17,421	17,421		17,421	0	17,421		7
8	TOTAL General Services	493,085	375,724	178,637	1,047,446	0	1,047,446	7,601	1,055,047		8
	B. Health Care and Programs										
9	Medical Director	0		11,549	11,549		11,549	0	11,549		9
10	Nursing and Medical Records	1,963,947	114,261	10,900	2,089,108		2,089,108	0	2,089,108		10
10a	Therapy	245,845	952	30,351	277,148		277,148	0	277,148		10a
11	Activities	226,753	3,543	555	230,851		230,851	0	230,851		11
12	Social Services	52,697		580	53,277		53,277	0	53,277		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			871	871		871	0	871		14
15	Other (specify):*				0		0	0	0		15
16	TOTAL Health Care and Programs	2,489,242	118,756	54,806	2,662,804	0	2,662,804	0	2,662,804		16
	C. General Administration										
17	Administrative	99,991		417,055	517,046		517,046	39,279	556,325		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			70,890	70,890		70,890	(7,669)	63,221		19
20	Dues, Fees, Subscriptions & Promotions			54,311	54,311		54,311	(29,922)	24,389		20
21	Clerical & General Office Expenses	184,420	37,702	190,014	412,136		412,136	(114,363)	297,773		21
22	Employee Benefits & Payroll Taxes			478,874	478,874	0	478,874	0	478,874		22
23	Inservice Training & Education			5,198	5,198		5,198	0	5,198		23
24	Travel and Seminar			15,223	15,223		15,223	(2,430)	12,793		24
25	Other Admin. Staff Transportation			0	0		0	1,597	1,597		25
26	Insurance-Prop.Liab.Malpractice			133,255	133,255		133,255	944	134,199		26
27	Other (specify):*			60,000	60,000		60,000	(33,564)	26,436		27
28	TOTAL General Administration	284,411	37,702	1,424,820	1,746,933	0	1,746,933	(146,128)	1,600,805		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,266,738	532,182	1,658,263	5,457,183	0	5,457,183	(138,527)	5,318,656		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.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	10,611
	REPAIRS & MAINTENANCE	0
		0
		10,611
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	49,317
	ELECTRICITY	46,354
	WATER	49,824
	CABLE TV - LOBBY	0
		0
		145,495
6	MAINTENANCE	
	GROUNDS MAINTENANCE	5,110
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	0
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	0
	FIRE SERVICE	0
		0
		0
		0
		5,110
7	OTHER	
	SCAVENGER	17,421
	SECURITY SERVICE	0
		0
		0
		17,421
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	11,549
		11,549

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,852
	PHARMACY CONSULTANT XVIII B 39-2	9,048
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		10,900
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	30,351
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		30,351
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	555
		0
		555
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	580
		0
		580
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	871
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	417,055
18	DIRECTORS FEES	
	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	18,653
	ADMINISTRATIVE CONSULTANTS XIX C	
	PROFESSIONAL FEES XIX C	52,237
		0
		70,890
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	24,073
	EMPLOYEE WANT ADS XIX F	8,983
	CONTRIBUTIONS VI 20 XIX F	410
	DUES & SUBSCRIPTIONS XIX F	9,857
	LICENSES & PERMITS XIX F	485
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	6,048
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	4,455
	PATIENT BACKGROUND CHECKS XIX F	0
		54,311
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	54
	EQUIPMENT REPAIR & MAINTENANCE	8,574
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	5,567
	HOME OFFICE EXPENSE	132,000
	THEFT & DAMAGE LOSS	60
	TELEPHONE	43,759
	MESSENGER SERVICE	0
		0
		190,014

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	247,434
	UNEMPLOYMENT COMPENSATION XIX D	50,456
	WORKERS COMPENSATION INSURANCE XIX D	90,710
	HOSPITALIZATION INSURANCE XIX D	49,772
	EMPLOYEE BENEFITS - OTHER XIX D	40,502
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		478,874
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	5,198
		5,198
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	15,223
		15,223
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	0
		0
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	133,255
		133,255
27	OTHER	
	BAD DEBTS VI 24	60,000
		60,000

GRAND TOTAL COLUMN 3 OTHER

1,658,263

MORTON TERRACE CARE CENTER
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2006

TOTAL FOOD PURCHASE	249,348	PATIENT MEALS	154302
LESS SALES TAX	(1,038)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	248,310	TOTAL MEALS/YEAR	154302
TOTAL PATIENT CENSUS	51,434	NET FOOD	248310
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	154302

TOTAL PATIENT MEALS	154302	COST PER MEAL	1.61
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY			-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number **MORTON TERRACE CARE CENTER**

#0045500

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			39,581	39,581		39,581	363,702	403,283			30
31	Amortization of Pre-Op. & Org.			0	0		0	278	278			31
32	Interest			186,262	186,262		186,262	301,101	487,363			32
33	Real Estate Taxes				0		0	61,166	61,166			33
34	Rent-Facility & Grounds			614,005	614,005		614,005	(604,794)	9,211			34
35	Rent-Equipment & Vehicles			59,343	59,343		59,343	0	59,343			35
36	Other (specify):*				0		0	0	0			36
37	TOTAL Ownership			899,191	899,191	0	899,191	121,453	1,020,644			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		154,345		154,345		154,345	0	154,345			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			90,885	90,885		90,885	0	90,885			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	154,345	90,885	245,230	0	245,230	0	245,230			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,266,738	686,527	2,648,339	6,601,604	0	6,601,604	(17,074)	6,584,530			45

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

Facility Name & ID Number **MORTON TERRACE CARE CENTER**

0045500

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,136)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(15,975)	30		9
10	Interest and Other Investment Income	(48)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,038)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(5,567)	21		18
19	Entertainment		20		19
20	Contributions	(6,458)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(10,000)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(60,000)	27		24
25	Fund Raising, Advertising and Promotional	(24,073)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule	(53,305)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (179,600)		\$ 0	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	2	
		Amount	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)	162,526		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 162,526		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (17,074)		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ID# 0045500

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	DEFERRED MAINTENANCE	\$ 0	1
2	MARKETING TRAVEL	(2,555)	24
3	MARKETING SALARY	(50,750)	21
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
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	(53,305)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MORTON TERRACE CARE CENTER# 0045500

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,174)	0	0	0	0	0	0	0	0	0	0	(4,174)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	5,761	0	0	0	0	0	0	0	0	5,761	5
6	Maintenance	0	0	6,014	0	0	0	0	0	0	0	0	6,014	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(4,174)	0	11,775	0	7,601	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	39,279	0	0	0	0	0	0	0	0	39,279	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(10,000)	0	2,331	0	0	0	0	0	0	0	0	(7,669)	19
20	Fees, Subscriptions & Promotions	(30,531)	0	609	0	0	0	0	0	0	0	0	(29,922)	20
21	Clerical & General Office Expenses	(56,317)	0	(58,046)	0	0	0	0	0	0	0	0	(114,363)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,555)	0	125	0	0	0	0	0	0	0	0	(2,430)	24
25	Other Admin. Staff Transportation	0	0	1,597	0	0	0	0	0	0	0	0	1,597	25
26	Insurance-Prop.Liab.Malpractice	0	0	944	0	0	0	0	0	0	0	0	944	26
27	Other (specify):*	(60,000)	0	26,436	0	0	0	0	0	0	0	0	(33,564)	27
28	TOTAL General Administration	(159,403)	0	13,275	0	(146,128)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(163,577)	0	25,050	0	(138,527)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MORTON TERRACE CARE CENTER

0045500

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	(15,975)	378,868	809	0	0	0	0	0	0	0	0	363,702	30
31	Amortization of Pre-Op. & Org.	0	278	0	0	0	0	0	0	0	0	0	278	31
32	Interest	(48)	301,149	0	0	0	0	0	0	0	0	0	301,101	32
33	Real Estate Taxes	0	61,166	0	0	0	0	0	0	0	0	0	61,166	33
34	Rent-Facility & Grounds	0	(614,005)	9,211	0	0	0	0	0	0	0	0	(604,794)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(16,023)	127,456	10,020	0	121,453	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(179,600)	127,456	35,070	0	(17,074)	45							

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	21 HOME OFFICE EXPENCE	\$ 132,000	PLATINUM HEALTH CARE LLC	100.00%	\$	\$ (132,000)
16	V	5 UTILITIES				5,761	5,761
17	V	6 REPAIRS & MAINTENANCE				6,014	6,014
18	V	17 ADMINISTRATIVE SALARY				39,279	39,279
19	V	19 PROFESSIONAL FEES				2,331	2,331
20	V	20 FEES, SUBSCRIPTIONS				609	609
21	V	21 OFFICE EXPENSE				73,954	73,954
22	V	24 EDUCATION & SEMINAR				125	125
23	V	25 TRAVEL				1,597	1,597
24	V	27 EMPLOYEE BENEFITS				26,436	26,436
25	V	26 INSURANCE				944	944
26	V	30 DEPRECIATION				809	809
27	V	34 OFFICE RENT				9,211	9,211
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 132,000			\$ 167,070	\$ * 35,070

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
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		\$			\$	0	\$ *	39

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

Facility Name & ID Number MORTON TERRACE CARE CENTER # 0045500 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MARK SHAPIRO		ADMINISTRATIVE		SEE ATTACHED			MGMT FEE	\$ 139,018	17-3	1
2	BRIAN LEVINSON		ADMINISTRATIVE					MGMT FEE	139,018	17-3	2
3	BEN KLEIN		ADMINISTRATIVE					MGMT FEE	139,019	17-3	3
4	BEN KLEIN		ADMINISTRATIVE					SALARY	14,208	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 431,263		13

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

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

Facility Name & ID Number MORTON TERRACE CARE CENTER

0045500

Report Period Beginning:

01/01/2006

Ending: 2/31/2006

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

Name of Related Organization PLATINUM HEALTH CARE LLC
 Street Address 7444 LONG AVE
 City / State / Zip Code SKOKIE, IL 60077
 Phone Number (847) 329-4100
 Fax Number (847) 329-4900

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	CENSUS DAYS	369,267	8	\$ 41,358	\$ 51,434	\$ 5,761	1
2	6	REPAIRS & MAINTENANCE	CENSUS DAYS	369,267	8	43,174	51,434	6,014	2
3	17	ADMINISTRATIVE SALARY	CENSUS DAYS	369,267	8	282,000	51,434	39,279	3
4	19	PROFESSIONAL FEES	CENSUS DAYS	369,267	8	16,736	51,434	2,331	4
5	20	FEES, SUBSCRIPTIONS	CENSUS DAYS	369,267	8	4,372	51,434	609	5
6	21	OFFICE EXPENSE	CENSUS DAYS	369,267	8	530,949	51,434	73,954	6
7	24	EDUCATION & SEMINAR	CENSUS DAYS	369,267	8	895	51,434	125	7
8	25	TRAVEL	CENSUS DAYS	369,267	8	11,467	51,434	1,597	8
9	27	EMPLOYEE BENEFITS	CENSUS DAYS	369,267	8	189,793	51,434	26,436	9
10	26	INSURANCE	CENSUS DAYS	369,267	8	6,774	51,434	944	10
11	30	DEPRECIATION	CENSUS DAYS	369,267	8	5,811	51,434	809	11
12	34	OFFICE RENT	CENSUS DAYS	369,267	8	66,129	51,434	9,211	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					\$ 1,199,458	\$ 711,429	\$ 167,070	25

Facility Name & ID Number

MORTON TERRACE CARE CENTER

0045500

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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	RELATED PARTY: MORTON TERRACE REALTY, LLC						\$	\$			\$	1						
2	CAPMARK		X	MORTGAGE	\$50,780.77	02/17/06	5,257,100	5,218,329	02/17/41	5.4000	245,036	2						
3	LOAN COSTS		X	LOAN COSTS	W/O OVER LOAN		128,989	125,918			3,071	3						
4												4						
5	RELATED PARTY ALLOCATION										7,240	5						
Working Capital																		
6	LASALLE BANK		X	WORKING CAPITAL			2,200,000	480,000		8.2500	118,586	6						
7	DR. TOM KLEIN		X				287,000				49,577	7						
8	ROBERT KAPLAN		X				344,000				18,099	8						
9	TOTAL Facility Related				\$50,780.77		\$ 8,217,089	\$ 5,824,247			\$ 441,609	9						
B. Non-Facility Related*																		
10	IRS, IDR, ETC		X	LATE FEES								10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 0	14						
15	TOTALS (line 9+line14)						\$ 8,217,089	\$ 5,824,247			\$ 441,609	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 45,802 Line # 32

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2005 report.	\$	74,166	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.)	\$	65,705	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(8,461)	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	0	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.)	\$	65,705	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.	\$	57,244	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	26,240	8
	2002	59,372	9
	2003	60,103	10
	2004	64,110	11
	2005	65,705	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2005 TAX BILL.

FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2005	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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. 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.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MORTON TERRACE CARE CENTER COUNTY TAZEWELL

FACILITY IDPH LICENSE NUMBER 0045500

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>06-06-29-115-003</u>	<u>NURSING HOME</u>	\$ <u>65,705.18</u>	\$ <u>65,705.18</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>65,705.18</u>	\$ <u>65,705.18</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number MORTON TERRACE CARE CENTER

0045500

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

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. (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? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

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

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1				\$ <u>197,521</u>	1
2					2
3	TOTALS			\$ 197,521	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4		2006		\$ 3,140,548	\$ 99,932	27.5	\$ 99,932	\$	\$ 99,932
5									
6									
7									
8	RELATED PARTY ALLOCATION				1,805		1,805		
	Improvement Type**								
9	ROOFTOP AC UNIT / CONDENSOR FAN		2001	5,040	183	27.5	183		963
10	ROOF REPAIRS		2001	1,900	69	27.5	69		367
11	DRY PIPE VALVE		2001	2,225	81	27.5	81		422
12	DOORS, LOCKS, ROOM SIGNS, WALLPAPER		2002	29,163	1,060	27.5	1,060		4,709
13	WALLAPER		2002	67,200	2,443	27.5	2,443		11,085
14	ROOFING, PARKING LOT REPAIR		2002	40,373	1,468	27.5	1,468		6,461
15	WATER HEATER, AIR COMPRESSOR		2002	15,986	582	27.5	582		2,502
16	ROOF TOP AC, CONCRETE WORK, MIXING VALVE, CLOSERS		2003	8,894	323	27.5	323		1,117
17	ROOF REPAIR, CONDENSOR, STORAGE		2004	36,866	1,341	27.5	1,341		3,297
18	SECURITY, PAGING SYSTEM		2005	9,400	342	27.5	342		500
19	GUTTERS, EXHAUST FAN		2005	5,632	205	27.5	205		298
20	PATIO/WALK REPAIR		2005	1,882	125	15	125		188
21	CONCRETE WALK W/ REMOVALS , EXIT SIGNS		2006	6,814	114	15	114		114
22	RE-ROOF-EAST,WEST, NORTH WINGS AND MANSARD		2006	24,500	408	27.5	408		408
23	INSTALLATION OF A NEW CARRIER FURNACE		2006	7,355	123	27.5	123		123
24	FLOORING - LOBBY, DINING ROOM		2006	43,890	732	27.5	732		732
25	INSTALLED NEW CONDENSER D-WING		2006	2,100	35	27.5	35		35
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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								67	
68								68	
69								69	
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70	
			3,449,768		111,371		111,371	0	133,253

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 110,913	\$ 20,544	\$ 11,091	\$ (9,453)		\$ 28,888	71
72	Current Year Purchases	47,015	9,403	4,701	(4,702)		9,722	72
73	Fully Depreciated Assets				0			73
74	RELATED PARTY ALLOCATION		277,940	276,120	(1,820)			74
75	TOTALS	\$ 157,928	\$ 307,887	\$ 291,912	\$ (15,975)		\$ 38,610	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	0		\$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 0	\$ 0	\$ 0	\$ 0		\$ 0	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)	\$ 3,805,217	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 419,258	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 403,283	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (15,975)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 171,863	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: **N/A RELATED PARTY**

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

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: \$ **39,163** Description: **SEE SCHEDULE ATTACHED**

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	BUSINESS	Toyota RAV4 2004	\$ #####	\$ 4,260	17
18	BUSINESS	Toyota RAV4 2006	519.00	3,770	18
19	BUSINESS	Ford Club Wagon 2003	721.00	8,678	19
20	BUSINESS	Honda Accord EX 2005	450.00	3,472	20
21	TOTAL		\$ #####	\$ 20,180	21

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. _____/2007 \$ _____

13. _____/2008 \$ _____

14. _____/2009 \$ _____

* 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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
<p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>		

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

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.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$			\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				126,836		126,836	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): RADIOLOGY,LAB.	39-2					27,509		27,509	13
14	TOTAL			\$		\$	\$ 154,345		\$ 154,345	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 CARE CENTER

0045500

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (79,781))	2,034,920		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	56,409		6
7	Other Prepaid Expenses	17,998		7
8	Accounts Receivable (owners or related parties)	2,254,830		8
9	Other(specify): INSURANCE ESCROW	39,100		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,403,257	\$ 0	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	309,220		15
16	Equipment, at Historical Cost	157,928		16
17	Accumulated Depreciation (book methods)	(125,738)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 341,410	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,744,667	\$ 0	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 405,940	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,647,667		29
30	Accrued Salaries Payable	155,261		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	36,674		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,245,542	\$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 0	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,245,542	\$ 0	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,499,125	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,744,667	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,153,117	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,153,117	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	346,008	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)	\$ 346,008	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,499,125	24 *

* This must agree with page 17, line 47.

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,699,168	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,699,168	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	245,260	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 245,260	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,136	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,136	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	48	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 48	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 0	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,947,612	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,047,446	31
32	Health Care	2,662,804	32
33	General Administration	1,746,933	33
	B. Capital Expense		
34	Ownership	899,191	34
	C. Ancillary Expense		
35	Special Cost Centers	154,345	35
36	Provider Participation Fee	90,885	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,601,604	40
41	Income before Income Taxes (line 30 minus line 40)**	346,008	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 346,008	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

TAX RETURN PREPARED ON CASH BASIS

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **MORTON TERRACE CARE CENTER**

0045500

Report Period Beginning: **01/01/2006**

Ending:

12/31/2006

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,115	1,952	\$ 58,174	\$ 29.80	1
2	Assistant Director of Nursing	1,944	1,848	55,607	30.09	2
3	Registered Nurses	9,649	8,920	254,116	28.49	3
4	Licensed Practical Nurses	29,905	28,446	658,446	23.15	4
5	CNAs & Orderlies	76,903	73,047	881,986	12.07	5
6	CNA Trainees					6
7	Licensed Therapist	6,961	6,581	223,686	33.99	7
8	Rehab/Therapy Aides	1,746	1,579	22,159	14.03	8
9	Activity Director	4,053	3,714	57,480	15.48	9
10	Activity Assistants	16,018	15,060	169,273	11.24	10
11	Social Service Workers	3,842	3,489	52,697	15.10	11
12	Dietician					12
13	Food Service Supervisor	1,950	1,838	24,396	13.27	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,650	20,548	191,626	9.33	15
16	Dishwashers					16
17	Maintenance Workers	2,782	2,631	34,783	13.22	17
18	Housekeepers	17,013	16,157	152,093	9.41	18
19	Laundry	9,885	9,181	90,187	9.82	19
20	Administrator	2,080	2,016	99,991	49.60	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,109	10,811	184,420	17.06	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	5,661	3,888	55,618	14.31	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	224,266	211,706	\$ 3,266,738 *	\$ 15.43	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 10,611	1-3	35
36	Medical Director	O	11,549	9-3	36
37	Medical Records Consultant	N	1,852	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	9,048	10-3	39
40	Physical Therapy Consultant	L	30,351	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	555	11-3	44
45	Social Service Consultant	E	580	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 64,546		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses		N/A	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
COLLEEN KAMIN	ADMIN	0	\$ 99,991	Workers' Compensation Insurance	\$ 90,710	IDPH License Fee	\$		
				Unemployment Compensation Insurance	50,456	Advertising: Employee Recruitment	8,983		
				FICA Taxes	247,434	Health Care Worker Background Check	1,484		
				Employee Health Insurance	49,772	(Indicate # of checks performed <u>212</u>)			
				Employee Meals	0	Patient Background Checks	212 2,971		
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	6,458		
				EMPLOYEE BENEFITS - OTHER	40,502	MARKETING/ADV/PROMO	24,073		
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	10,342		
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOCATION	609		
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(6,458)		
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)		
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(24,073)		
						Yellow page advertising	(0)		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 99,991	TOTAL (agree to Schedule V, line 22, col.8)	\$ 478,874	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 24,389		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
MANAGEMENT FEES			\$ 417,055			\$	Out-of-State Travel	\$	
							In-State Travel	15,223	
							MGMT CO ALLOCATION	1,597	
							Seminar Expense	0	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 417,055	TOTAL		\$	Entertainment Expense	()	
C. Professional Services								TOTAL (agree to Sch. V, line 24, col. 8)	\$ 16,820
Vendor/Payee	Type		Amount						
			\$						
SEE ATTACHED SCHEDULE			70,890						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 70,890						

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number **MORTON TERRACE CARE CENTER**# **0045500**Report Period Beginning: **01/01/2006**Ending: **12/31/2006****XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL ON LONG TERM CARE \$7005
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ YES Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 90,885
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? 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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
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: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees