

		FOR BHF USE					

LL1

**2007**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2007)**

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:** 0045500

**Facility Name:** MORTON TERRACE CARE CENTER

**Address:** 191 EAST QUEENWOOD ROAD MORTON 61550  
 Number City Zip Code

**County:** TAZEWELL

**Telephone Number:** ( 309 ) 866-5331 **Fax #** ( 309 ) 866-9376

**HFS ID Number:** 36-4438626

**Date of Initial License for Current Owners:** 08/01

**Type of Ownership:**

<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
<b>IRS Exemption Code</b> _____	<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 _____	

**In the event there are further questions about this report, please contact:**  
**Name:** DARRYL BUEKER **Telephone Number:** ( 417 ) 865-8701

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/01/07 to 12/31/07 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) _____	(Title) _____
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) <u>DARRYL BUEKER, CPA</u>	
	(Firm Name & Address) <u>BKD, LLP</u> <u>P, O. BOX 1190, SPRINGFIELD, MO 65801-1190</u>	
	(Telephone) <u>( 417 ) 865-8701</u> Fax # <u>(417) 865-0682</u>	

**MAIL TO: BUREAU OF HEALTH FINANCE**  
**ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES**  
 201 S. Grand Avenue East  
 Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number MORTON TERRACE CARE CENTER

# 0045500 Report Period Beginning: 1/01/07 Ending: 12/31/07

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	40,288		6,797	47,085	8
9	SNF/PED					9
10	ICF		4,746		4,746	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,288	4,746	6,797	51,831	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.59%

D. How many bed-hold days during this year were paid by the Department? \_\_\_\_\_ (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 7/ 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 44 and days of care provided 6,073

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number **MORTON TERRACE CARE CENTER** # **0045500** Report Period Beginning: **1/01/07** Ending: **12/31/07**

**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 BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	268,422	33,613	8,934	310,969		310,969		310,969			1
2	Food Purchase		286,867		286,867		286,867	(4,297)	282,570			2
3	Housekeeping	157,904	30,108		188,012		188,012		188,012			3
4	Laundry	75,972	16,476	561	93,009		93,009		93,009			4
5	Heat and Other Utilities			181,584	181,584		181,584	5,651	187,235			5
6	Maintenance	53,392		94,220	147,612		147,612	5,876	153,488			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	<b>555,690</b>	<b>367,064</b>	<b>285,299</b>	<b>1,208,053</b>		<b>1,208,053</b>	<b>7,230</b>	<b>1,215,283</b>			<b>8</b>
	<b>B. Health Care and Programs</b>											
9	Medical Director			14,002	14,002		14,002		14,002			9
10	Nursing and Medical Records	1,949,106	141,550	10,668	2,101,324		2,101,324		2,101,324			10
10a	Therapy	306,975	442	1,499	308,916		308,916		308,916			10a
11	Activities	242,419	7,452	(510)	249,361		249,361		249,361			11
12	Social Services	54,056		1,020	55,076		55,076		55,076			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	<b>2,552,556</b>	<b>149,444</b>	<b>26,679</b>	<b>2,728,679</b>		<b>2,728,679</b>		<b>2,728,679</b>			<b>16</b>
	<b>C. General Administration</b>											
17	Administrative	90,181		623,640	713,821		713,821	(152,721)	561,100			17
18	Directors Fees											18
19	Professional Services			86,242	86,242		86,242	5,970	92,212			19
20	Dues, Fees, Subscriptions & Promotions			32,418	32,418		32,418	(13,692)	18,726			20
21	Clerical & General Office Expenses	256,758	38,746	55,593	351,097		351,097	66,456	417,553			21
22	Employee Benefits & Payroll Taxes			496,004	496,004		496,004		496,004			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,783	6,783		6,783		6,783			24
25	Other Admin. Staff Transportation			21,453	21,453		21,453	11,662	33,115			25
26	Insurance-Prop.Liab.Malpractice			114,932	114,932		114,932	816	115,748			26
27	Other (specify):*							23,115	23,115			27
28	<b>TOTAL General Administration</b>	<b>346,939</b>	<b>38,746</b>	<b>1,437,065</b>	<b>1,822,750</b>		<b>1,822,750</b>	<b>(58,394)</b>	<b>1,764,356</b>			<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,455,185</b>	<b>555,254</b>	<b>1,749,043</b>	<b>5,759,482</b>		<b>5,759,482</b>	<b>(51,164)</b>	<b>5,708,318</b>			<b>29</b>

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number MORTON TERRACE CARE CENTER #0045500 Report Period Beginning: 1/01/07 Ending: 12/31/07

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			53,531	53,531		53,531	441,394	494,925		30
31	Amortization of Pre-Op. & Org.							145	145		31
32	Interest			216,308	216,308		216,308	319,459	535,767		32
33	Real Estate Taxes			67,698	67,698		67,698		67,698		33
34	Rent-Facility & Grounds			723,003	723,003		723,003	(723,003)			34
35	Rent-Equipment & Vehicles			75,224	75,224		75,224	724	75,948		35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			1,135,764	1,135,764		1,135,764	38,719	1,174,483		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers			212,083	212,083		212,083		212,083		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			90,885	90,885		90,885		90,885		42
43	Other (specify):*							(68,031)	(68,031)		43
44	<b>TOTAL Special Cost Centers</b>			302,968	302,968		302,968	(68,031)	234,937		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,455,185	555,254	3,187,775	7,198,214		7,198,214	(80,476)	7,117,738		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: 1/01/07

Ending: 12/31/07

**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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,264)	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	(13,708)	30		9
10	Interest and Other Investment Income	(1)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(33)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,257)	21		18
19	Entertainment				19
20	Contributions	(5,210)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(12,001)	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	(73,717)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (110,191)</b>		<b>\$</b>	<b>30</b>

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)	29,715		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ 29,715</b>		<b>36</b>
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	<b>\$ (80,476)</b>		<b>37</b>

\*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.			\$		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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

BHF USE ONLY						
48		49		50		51
						52

MORTON TERRACE CARE CENTER

ID# 0045500

Report Period Beginning: 1/01/07

Ending: 12/31/07

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	IL COUNCIL LTC-COPE	\$ (2,026)	20	1
2	MISC. INCOME	(1,549)	21	2
3	MARKETING SALARIES	(59,491)	43	3
4	MARKETING EMPLOYEE BENEFITS	(8,540)	43	4
5	REAL ESTATE TAXES	(2,111)	33	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	<b>Total</b>	(73,717)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number MORTON TERRACE CARE CENTER

# 0045500

Report Period Beginning:

1/01/07

Ending:

12/31/07

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,297)	0	0	0	0	0	0	0	0	0	0	(4,297)	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	5,651	0	0	0	0	0	0	0	0	5,651	5
6	Maintenance	0	0	5,876	0	0	0	0	0	0	0	0	5,876	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(4,297)</b>	<b>0</b>	<b>11,527</b>	<b>0</b>	<b>7,230</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	(152,721)	0	0	0	0	0	0	0	0	(152,721)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	5,970	0	0	0	0	0	0	0	0	5,970	19
20	Fees, Subscriptions & Promotions	(14,027)	0	335	0	0	0	0	0	0	0	0	(13,692)	20
21	Clerical & General Office Expenses	(8,016)	0	74,472	0	0	0	0	0	0	0	0	66,456	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	11,662	0	0	0	0	0	0	0	0	11,662	25
26	Insurance-Prop.Liab.Malpractice	0	0	816	0	0	0	0	0	0	0	0	816	26
27	Other (specify):*	0	0	23,115	0	0	0	0	0	0	0	0	23,115	27
28	<b>TOTAL General Administration</b>	<b>(22,043)</b>	<b>0</b>	<b>(36,351)</b>	<b>0</b>	<b>(58,394)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(26,340)</b>	<b>0</b>	<b>(24,824)</b>	<b>0</b>	<b>(51,164)</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MORTON TERRACE CARE CENTER

# 0045500

Report Period Beginning:

1/01/07

Ending:

12/31/07

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(13,708)	452,157	2,945	0	0	0	0	0	0	0	0	441,394	30
31	Amortization of Pre-Op. & Org.	0	0	145	0	0	0	0	0	0	0	0	145	31
32	Interest	(1)	315,725	3,735	0	0	0	0	0	0	0	0	319,459	32
33	Real Estate Taxes	(2,111)	0	2,111	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(723,003)	0	0	0	0	0	0	0	0	0	(723,003)	34
35	Rent-Equipment & Vehicles	0	0	724	0	0	0	0	0	0	0	0	724	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(15,820)</b>	<b>44,879</b>	<b>9,660</b>	<b>0</b>	<b>38,719</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(68,031)	0	0	0	0	0	0	0	0	0	0	(68,031)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(68,031)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(68,031)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(110,191)</b>	<b>44,879</b>	<b>(15,164)</b>	<b>0</b>	<b>(80,476)</b>	<b>45</b>							

Facility Name & ID Number MORTON TERRACE CARE CENTER

# 0045500

Report Period Beginning:

1/01/07

Ending:

12/31/07

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

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

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		
1	V	34 RENT	\$ 723,003	MORTON TERRACE REALTY, LLC		\$	(723,003)	1
2	V	30 DEPRECIATION				452,157	452,157	2
3	V	32 INTEREST				280,218	280,218	3
4	V	32 MORTGAGE INSURANCE				31,822	31,822	4
5	V	32 AMORTIZATION-LOAN COSTS				3,685	3,685	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		\$ 723,003			\$ 767,882	\$ * 44,879	14

\* 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: **1/01/07**Ending: **12/31/07****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	17 Home Office	\$ 174,000	Platinum Health Care, LLC	100.00%	\$	\$ (174,000)	15
16	V	5 Utilities		Platinum Health Care, LLC		5,651	5,651	16
17	V	6 Repairs & Maintenance		Platinum Health Care, LLC		5,876	5,876	17
18	V	17 Administrative Salary		Platinum Health Care, LLC		21,279	21,279	18
19	V	19 Professional Fees		Platinum Health Care, LLC		5,970	5,970	19
20	V	20 Fees, Subscriptions		Platinum Health Care, LLC		335	335	20
21	V	21 Clerical Salaries		Platinum Health Care, LLC		62,670	62,670	21
22	V	21 Office Expenses		Platinum Health Care, LLC		11,802	11,802	22
23	V	25 Travel		Platinum Health Care, LLC		11,662	11,662	23
24	V	26 Insurance		Platinum Health Care, LLC		816	816	24
25	V	27 Employee Benefits		Platinum Health Care, LLC		23,115	23,115	25
26	V	30 Depreciation		Platinum Health Care, LLC		805	805	26
27	V	35 Equipment Rental		Platinum Health Care, LLC		724	724	27
28	V	31 Amortization		Platinum Health Care, LLC		145	145	28
29	V	30 Depreciation		Platinum Health Care, LLC		2,140	2,140	29
30	V	32 Interest		Platinum Health Care, LLC		3,735	3,735	30
31	V	33 Real Estate Taxes		Platinum Health Care, LLC		2,111	2,111	31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 174,000			\$ 158,836	\$ * (15,164)	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: 1/01/07 Ending: 12/31/07

## 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	Ben Klein		Administrative	21.68	SEE ATTACHED	2	5.00	Mgt Fees	\$ 149,880	17-3	1
2	Brian Levinson		Administrative	21.67		4	10.00	Mgt Fees	149,880	17-3	2
3	Mark Shapiro		Administrative	21.67		6	15.00	Mgt Fees	149,880	17-3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 449,640		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:

1/01/07

Ending: 12/31/07

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 ) 329-7652

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	Patient Days	445,050	11	\$ 48,520	\$ 51,831	\$ 5,651	1
2	6	Repairs & Maintenance	Patient Days	445,050	11	50,451	51,831	5,876	2
3	17	Administrative Salary	Patient Days	445,050	11	182,711	182,711	21,279	3
4	19	Professional Fees	Patient Days	445,050	11	51,264	51,831	5,970	4
5	20	Fees, Subscriptions	Patient Days	445,050	11	2,875	51,831	335	5
6	21	Clerical Salaries	Patient Days	445,050	11	538,120	538,120	62,670	6
7	21	Office Expenses	Patient Days	445,050	11	101,335	51,831	11,802	7
8	25	Travel	Patient Days	445,050	11	100,136	51,831	11,662	8
9	26	Insurance	Patient Days	445,050	11	7,006	51,831	816	9
10	27	Employee Benefits	Patient Days	445,050	11	198,477	51,831	23,115	10
11	30	Depreciation	Patient Days	445,050	11	6,916	51,831	805	11
12	35	Equipment Rental	Patient Days	445,050	11	6,218	51,831	724	12
13	31	Amortization	Patient Days	445,050	11	1,246	51,831	145	13
14	30	Depreciation	Patient Days	445,050	11	18,376	51,831	2,140	14
15	32	Interest	Patient Days	445,050	11	32,071	51,831	3,735	15
16	33	Real Estate Taxes	Patient Days	445,050	11	18,130	51,831	2,111	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,363,852	\$ 720,831	\$ 158,836	25

**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		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			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1	MORTON TERRACE REALTY						\$	\$		\$	1						
2			X	MORTGAGE			5,257,100		3/1/41	5.4000	280,218	2					
3				LOAN COSTS							3,685	3					
4				MORTGAGE INSURANCE							31,822	4					
5												5					
<b>Working Capital</b>																	
6	LASALLE BANK		X	WORKING CAPITAL				1,671,671		7.7500	149,532	6					
7	DR. TOM KLEIN		X					287,000			49,576	7					
8	ROBERT KAPLAN		X					332,000			17,199	8					
9	TOTAL Facility Related						\$ 5,257,100	\$ 2,290,671			\$ 532,032	9					
<b>B. Non-Facility Related*</b>																	
10												10					
11												11					
12												12					
13	Allocation from Platinum										3,735	13					
14	TOTAL Non-Facility Related						\$	\$			\$ 3,735	14					
15	TOTALS (line 9+line14)						\$ 5,257,100	\$ 2,290,671			\$ 535,767	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 31,822 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.)



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

**2006 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 DARRYL BUEKER

TELEPHONE ( 417 ) 865-8701 FAX #: ( 417 ) 865-0682

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

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(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>67,403.06</u>	\$ <u>67,403.06</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>67,403.06</u>	\$ <u>67,403.06</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**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:

1/01/07 Ending:

12/31/07

**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:**

A. Land.

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

Facility Name & ID Number **MORTON TERRACE CARE CENTER**# **0045500**

Report Period Beginning:

1/01/07

Ending:

12/31/07

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			2006		\$ 3,140,548	\$ 114,202	27.5	\$ 114,202	\$ (0)	\$ 214,134	4
5											5
6											6
7											7
8											8
		<b>Improvement Type**</b>									
9		ROOFTOP AC UNIT / CONDENSOR FAN		2001	5,040		27.5	183	183	1,146	9
10		ROOF REPAIRS		2001	1,900		27.5	69	69	436	10
11		DRY PIPE VALVE		2001	2,225		27.5	81	81	503	11
12		DOORS, LOCKS, ROOM SIGNS, WALLPAPER		2002	29,163		27.5	1,060	1,060	5,769	12
13		WALLAPER		2002	67,200		27.5	2,444	2,444	13,529	13
14		ROOFING, PARKING LOT REPAIR		2002	40,373		27.5	1,468	1,468	7,929	14
15		WATER HEATER, AIR COMPRESSOR		2002	15,986		27.5	581	581	3,083	15
16		ROOF TOP AC, CONCRETE WORK, MIXING VALVE, CLOSERS		2003	8,894		27.5	323	323	1,440	16
17		ROOF REPAIR, CONDENSOR, STORAGE		2004	36,866		27.5	1,341	1,341	4,638	17
18		SECURITY, PAGING SYSTEM		2005	9,400		27.5	342	342	842	18
19		GUTTERS, EXHAUST FAN		2005	5,632		27.5	205	205	503	19
20		PATIO/WALK REPAIR		2005	1,882		15	125	125	313	20
21		CONCRETE WALK W/ REMOVALS , EXIT SIGNS		2006	6,814		15	454	454	568	21
22		RE-ROOF-EAST, WEST, NORTH WINGS AND MANSARD		2006	24,500		27.5	891	891	1,299	22
23		INSTALLATION OF A NEW CARRIER FURNACE		2006	7,355		27.5	267	267	390	23
24		FLOORING - LOBBY, DINING ROOM		2006	43,890		27.5	1,596	1,596	2,328	24
25		INSTALLED NEW CONDENSER D-WING		2006	2,100		27.5	76	76	111	25
26		B WING FLOORING		2007	25,000		10	2,500	2,500	2,500	26
27		CHAIRS, ETC		2007	11,590		15	708	708	708	27
28		MIXER/AMPLIFIER		2007	1,845		10	185	185	185	28
29		SHOWER ROOM		2007	16,990		27.5	566	566	566	29
30		C WING TILE		2007	20,000		10	1,500	1,500	1,500	30
31		BATHROOM REMODEL		2007	26,000		27.5	630	630	630	31
32		HOT WATER HEATER		2007	1,700		10	128	128	128	32
33		WATER HEATER A WING KITCHEN		2007	1,900		10	143	143	143	33
34		D WING REMODEL		2007	20,000		27.5	485	485	485	34
35		ROOFTOP UNIT		2007	11,540		10	673	673	673	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number MORTON TERRACE CARE CENTER

# 0045500

Report Period Beginning:

1/01/07

Ending:

12/31/07

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	REMODEL RES ROOMS	2007	\$ 26,200	\$	27.5	\$ 556	\$ 556	\$ 556	37
38	INSTALL DRYER	2007	3,709		10	216	216	216	38
39	INSTALL 3 TON SEER A/C	2007	1,750		5	204	204	204	39
40	HALL & ROOM VINYL TILES	2007	56,790		10	2,840	2,840	2,840	40
41	DRAPES	2007	2,424		5	242	242	242	41
42	A WING REMODELING	2007	20,000		27.5	364	364	364	42
43	D WING REMODELING	2007	28,040		27.5	340	340	340	43
44	E WING REMODELING	2007	47,790		27.5	434	434	434	44
45	A WING REMODELING	2007	48,540		27.5	294	294	294	45
46	B WING REMODELING	2007	79,540		27.5				46
47	REMODEL HALL BTY SHOP,	2007	7,960		27.5	96	96	96	47
48				24,890			(24,890)		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	Allocation from Platinum			961		961			67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,909,076	\$ 140,053		\$ 139,775	\$ (278)	\$ 272,067	70

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

Facility Name & ID Number MORTON TERRACE CARE CENTER # 0045500 Report Period Beginning: 1/01/07 Ending: 12/31/07

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	\$ 157,928	\$ 27,781	\$ 14,817	\$ (12,964)		\$ 61,228	71
72	Current Year Purchases	4,300	860	394	(466)		394	72
73	Fully Depreciated Assets							73
74	Related Party Allocation		339,939	339,939				74
75	TOTALS	\$ 162,228	\$ 368,580	\$ 355,150	\$ (13,430)		\$ 61,622	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,268,825	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 508,633	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 494,925	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (13,708)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 333,689	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: \_\_\_\_\_

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	<b>TOTAL</b>				\$ _____			7

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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 57,551 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			\$ <u>See Attached Schedule</u>	\$ <u>17,673</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ _____	\$ <u>17,673</u>	21

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

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

Facility Name & ID Number MORTON TERRACE CARE CENTER # 0045500 Report Period Beginning: 1/01/07 Ending: 12/31/07

**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>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		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)	
<b>TOTAL TRAINED</b>	

- (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	10a-3	hrs			1,499			1,499	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 prescrpts				196,564		196,564	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab/X-ray	39-2					15,519		15,519	13
14	<b>TOTAL</b>			\$		\$ 1,499	\$ 212,083		\$ 213,582	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: **1/01/07**

Ending:

**12/31/07**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/07**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 40,951	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 45,774 )	2,141,173		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	65,909		6
7	Other Prepaid Expenses	5,862		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	2,025,741		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 4,279,636	\$	10
<b>B. Long-Term Assets</b>				
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	768,528		15
16	Equipment, at Historical Cost	162,228		16
17	Accumulated Depreciation (book methods)	(179,269)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 751,487	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,031,123	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 439,622	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,290,671		29
30	Accrued Salaries Payable	162,848		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	66,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	Accrued Expenses	133,112		36
37	Due Others, Adv Billing	217,310		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 3,309,563	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,309,563	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,721,560	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 5,031,123	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,499,125	1
2	Restatements (describe):		2
3	<b>Rounding</b>	2	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,499,127	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	222,433	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 222,433	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 1,721,560	24 *

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

Facility Name & ID Number MORTON TERRACE CARE CENTER# 0045500Report Period Beginning: 1/01/07Ending: 12/31/07**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 6,141,133	1
2	Discounts and Allowances for all Levels	(346,592)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 5,794,541</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,341,368	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 1,341,368</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
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	(462)	13
14	Non-Patient Meals	4,264	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	267,252	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,686	19
20	Radiology and X-Ray	2,448	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 283,188</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 1</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28		1,549	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 1,549</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 7,420,647</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,208,053	31
32	Health Care	2,728,679	32
33	General Administration	1,822,750	33
<b>B. Capital Expense</b>			
34	Ownership	1,135,764	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	212,083	35
36	Provider Participation Fee	90,885	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 7,198,214</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>222,433</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 222,433</b>	<b>43</b>

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ 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 CARE CENTER**

# **0045500**

Report Period Beginning:

1/01/07

Ending:

12/31/07

**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	1,956	2,080	\$ 67,805	\$ 32.60	1
2	Assistant Director of Nursing	2,221	2,368	68,686	29.01	2
3	Registered Nurses	8,540	9,177	285,295	31.09	3
4	Licensed Practical Nurses	27,760	29,054	656,841	22.61	4
5	CNAs & Orderlies	73,251	78,465	870,479	11.09	5
6	CNA Trainees					6
7	Licensed Therapist	2,078	2,302	107,480	46.69	7
8	Rehab/Therapy Aides	7,920	8,583	199,495	23.24	8
9	Activity Director	3,819	4,063	57,347	14.11	9
10	Activity Assistants	16,838	18,216	185,072	10.16	10
11	Social Service Workers	3,512	3,808	54,056	14.20	11
12	Dietician					12
13	Food Service Supervisor	1,606	2,049	32,325	15.78	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,576	24,512	236,097	9.63	15
16	Dishwashers					16
17	Maintenance Workers	3,847	4,148	53,392	12.87	17
18	Housekeepers	15,637	17,178	157,904	9.19	18
19	Laundry	7,785	8,355	75,972	9.09	19
20	Administrator	2,011	2,080	90,181	43.36	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,407	16,078	256,758	15.97	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	215,764	232,516	\$ 3,455,185 *	\$ 14.86	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	194	\$ 8,636	1-3	35
36	Medical Director	Monthly	14,002	9-3	36
37	Medical Records Consultant	Monthly	1,620	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	9,048	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	17	1,020	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	211	\$ 34,326		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	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 &amp; ID Number MORTON TERRACE CARE CENTER

# 0045500

Report Period Beginning: 1/01/07

Ending: 12/31/07

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. IL COUNCIL LTC \$8,537
- (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? \_\_\_\_\_
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,190 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? \_\_\_\_\_  
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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees.