

		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: 0045518

Facility Name: MORTON VILLA CARE CENTER

Address: 190 EAST QUEENWOOD MORTON 61550
 Number City Zip Code

County: TAZEWELL

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

HFS ID Number: 36-4438536

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

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
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 _____	

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 01/01/07 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.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) _____	
	(Title) _____	
Paid Preparer	(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 VILLA CARE CENTER

0045518 Report Period Beginning: 01/01/07 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	106	Skilled (SNF)	106	38,690	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	106	TOTALS	106	38,690	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	25,143	3,532	4,415	33,090	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,143	3,532	4,415	33,090	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.53%

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)

N/A

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

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 07/17/2001

J. Was the facility purchased or leased after January 1, 1978?

YES Date 07/17/2001 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 106 and days of care provided 3,670

Medicare Intermediary ADMINISTAR

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 VILLA CARE CENTER # 0045518 Report Period Beginning: 01/01/07 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
	A. General Services										
1	Dietary	172,455	19,025	7,176	198,656		198,656		198,656		1
2	Food Purchase		184,868		184,868		184,868	(22)	184,846		2
3	Housekeeping	113,080	21,683		134,763		134,763		134,763		3
4	Laundry	41,841	17,005	2,741	61,587		61,587		61,587		4
5	Heat and Other Utilities			143,705	143,705		143,705	3,608	147,313		5
6	Maintenance	32,946	15	64,278	97,239		97,239	3,751	100,990		6
7	Other (specify):*										7
8	TOTAL General Services	360,322	242,596	217,900	820,818		820,818	7,337	828,155		8
	B. Health Care and Programs										
9	Medical Director			12,042	12,042		12,042		12,042		9
10	Nursing and Medical Records	1,486,981	117,707	6,360	1,611,048		1,611,048		1,611,048		10
10a	Therapy	381,647		1,151	382,798		382,798		382,798		10a
11	Activities	73,650	2,270	2,375	78,295		78,295		78,295		11
12	Social Services	27,216		2,924	30,140		30,140		30,140		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,969,494	119,977	24,852	2,114,323		2,114,323		2,114,323		16
	C. General Administration										
17	Administrative	58,019		390,222	448,241		448,241	(96,415)	351,826		17
18	Directors Fees										18
19	Professional Services			208,142	208,142		208,142	3,812	211,954		19
20	Dues, Fees, Subscriptions & Promotions			37,205	37,205		37,205	(14,407)	22,798		20
21	Clerical & General Office Expenses	59,564	28,743	118,631	206,938		206,938	(9,546)	197,392		21
22	Employee Benefits & Payroll Taxes			390,798	390,798		390,798		390,798		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,690	3,690		3,690		3,690		24
25	Other Admin. Staff Transportation			14,500	14,500		14,500	5,818	20,318		25
26	Insurance-Prop.Liab.Malpractice			92,322	92,322		92,322	521	92,843		26
27	Other (specify):*							14,757	14,757		27
28	TOTAL General Administration	117,583	28,743	1,255,510	1,401,836		1,401,836	(95,460)	1,306,376		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,447,399	391,316	1,498,262	4,336,977		4,336,977	(88,123)	4,248,854		29

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

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

Facility Name & ID Number MORTON VILLA CARE CENTER

#0045518

Report Period Beginning:

01/01/07

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	
	D. Ownership											
30	Depreciation			37,666	37,666		37,666	181,898	219,564			30
31	Amortization of Pre-Op. & Org.							93	93			31
32	Interest			26,758	26,758		26,758	206,057	232,815			32
33	Real Estate Taxes			36,893	36,893		36,893	1,348	38,241			33
34	Rent-Facility & Grounds			490,116	490,116		490,116	(490,116)				34
35	Rent-Equipment & Vehicles			56,003	56,003		56,003	462	56,465			35
36	Other (specify):*											36
37	TOTAL Ownership			647,436	647,436		647,436	(100,258)	547,178			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			136,961	136,961		136,961		136,961			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			57,829	57,829		57,829		57,829			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			194,790	194,790		194,790		194,790			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,447,399	391,316	2,340,488	5,179,203		5,179,203	(188,381)	4,990,822			45

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

Facility Name & ID Number MORTON VILLA CARE CENTER

0045518

Report Period Beginning: 01/01/07

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
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	(15,535)	30		9
10	Interest and Other Investment Income	(25)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(22)	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	(51,972)	21		18
19	Entertainment				19
20	Contributions	(3,500)	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	(13,327)	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 MISC INCOME	(4,538)	VAR		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (88,919)		\$	30

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)			34
35	Other- Attach Schedule	(99,462)	VAR	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (99,462)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (188,381)		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

BHF USE ONLY						
48		49		50		51
						52

STATE OF ILLINOIS
MORTON VILLA CARE CENTER

ID# 0045518
Report Period Beginning: 01/01/07
Ending: 12/31/07

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MISC INCOME	\$ (1,617)	21	1
2	MARKETING TRAVEL	(1,627)	25	2
3	IL COUNCIL LTC-COPE	(1,294)	20	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
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	(4,538)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MORTON VILLA CARE CENTER

0045518

Report Period Beginning:

01/01/07

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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(22)	0	0	0	0	0	0	0	0	0	0	(22)	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	3,608	0	0	0	0	0	0	0	0	3,608	5
6	Maintenance	0	0	3,751	0	0	0	0	0	0	0	0	3,751	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(22)	0	7,359	0	7,337	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	(96,415)	0	0	0	0	0	0	0	0	(96,415)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	3,812	0	0	0	0	0	0	0	0	3,812	19
20	Fees, Subscriptions & Promotions	(14,621)	0	214	0	0	0	0	0	0	0	0	(14,407)	20
21	Clerical & General Office Expenses	(57,089)	0	47,543	0	0	0	0	0	0	0	0	(9,546)	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	(1,627)	0	7,445	0	0	0	0	0	0	0	0	5,818	25
26	Insurance-Prop.Liab.Malpractice	0	0	521	0	0	0	0	0	0	0	0	521	26
27	Other (specify):*	0	0	14,757	0	0	0	0	0	0	0	0	14,757	27
28	TOTAL General Administration	(73,337)	0	(22,123)	0	(95,460)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(73,359)	0	(14,764)	0	(88,123)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MORTON VILLA CARE CENTER

0045518

Report Period Beginning:

01/01/07 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	(15,535)	195,553	1,880	0	0	0	0	0	0	0	0	181,898	30
31	Amortization of Pre-Op. & Org.	0	0	93	0	0	0	0	0	0	0	0	93	31
32	Interest	(25)	203,697	2,385	0	0	0	0	0	0	0	0	206,057	32
33	Real Estate Taxes	0	0	1,348	0	0	0	0	0	0	0	0	1,348	33
34	Rent-Facility & Grounds	0	(490,116)	0	0	0	0	0	0	0	0	0	(490,116)	34
35	Rent-Equipment & Vehicles	0	0	462	0	0	0	0	0	0	0	0	462	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(15,560)	(90,866)	6,168	0	(100,258)	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)	(88,919)	(90,866)	(8,596)	0	(188,381)	45							

Facility Name & ID Number MORTON VILLA CARE CENTER

0045518

Report Period Beginning:

01/01/07

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 RENTAL INCOME	\$ 490,116	MORTON VILLA REALTY, LLC		\$	\$ (490,116)	1
2	V	30 DEPRECIATION		MORTON VILLA REALTY, LLC		195,553	195,553	2
3	V	32 INTEREST		MORTON VILLA REALTY, LLC		200,834	200,834	3
4	V	32 AMORTIZATION-LOAN COSTS		MORTON VILLA REALTY, LLC		2,863	2,863	4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 490,116			\$ 399,250	\$ * (90,866)	14

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

Facility Name & ID Number **MORTON VILLA CARE CENTER**# **0045518**Report Period Beginning: **01/01/07**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	\$ 110,000	Platinum Health Care, LLC		\$	(110,000)	15
16	V	5 Utilities		Platinum Health Care, LLC		3,608	3,608	16
17	V	6 Repairs & Maintenance		Platinum Health Care, LLC		3,751	3,751	17
18	V	17 Administrative Salary		Platinum Health Care, LLC		13,585	13,585	18
19	V	19 Professional Fees		Platinum Health Care, LLC		3,812	3,812	19
20	V	20 Fees, Subscriptions		Platinum Health Care, LLC		214	214	20
21	V	21 Clerical Salaries		Platinum Health Care, LLC		40,010	40,010	21
22	V	21 Office Expenses		Platinum Health Care, LLC		7,533	7,533	22
23	V	25 Travel		Platinum Health Care, LLC		7,445	7,445	23
24	V	26 Insurance		Platinum Health Care, LLC		521	521	24
25	V	27 Employee Benefits		Platinum Health Care, LLC		14,757	14,757	25
26	V	30 Depreciation		Platinum Health Care, LLC		514	514	26
27	V	35 Equipment Rental		Platinum Health Care, LLC		462	462	27
28	V	31 Amortization		Platinum Health Care, LLC		93	93	28
29	V	30 Depreciation		Platinum Health Care, LLC		1,366	1,366	29
30	V	32 Interest		Platinum Health Care, LLC		2,385	2,385	30
31	V	33 Real Estate Taxes		Platinum Health Care, LLC		1,348	1,348	31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 110,000			\$ 101,404	\$ * (8,596)	39

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

Facility Name & ID Number MORTON VILLA CARE CENTER # 0045518 Report Period Beginning: 01/01/07 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	OWNER	ADMINISTRATIVE	33.30	See Attached	2	5.70	MGMT FEES	\$ 93,407	17-3	1
2	BRIAN LEVINSON	OWNER	ADMINISTRATIVE	33.30	See Attached	7	17.50	MGMT FEES	93,408	17-3	2
3	MARK SHAPIRO	OWNER	ADMINISTRATIVE	33.30	See Attached	6	15.00	MGMT FEES	93,407	17-3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 280,222		13

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

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

Facility Name & ID Number MORTON VILLA CARE CENTER

0045518

Report Period Beginning: 01/01/07

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

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

Name of Related Organization Platinum Healthcare, LLC
 Street Address 7444 Long Ave.
 City / State / Zip Code Skokie, IL 60077
 Phone Number (847-329-4100
 Fax Number (847-329-7652

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	\$ 33,090	\$ 3,608	1
2	6	Repairs & Maintenance	Patient Days	445,050	11	50,451	33,090	3,751	2
3	17	Administrative Salary	Patient Days	445,050	11	182,711	182,711	13,585	3
4	19	Professional Fees	Patient Days	445,050	11	51,264	33,090	3,812	4
5	20	Fees, Subscriptions	Patient Days	445,050	11	2,875	33,090	214	5
6	21	Clerical Salaries	Patient Days	445,050	11	538,120	538,120	40,010	6
7	21	Office Expenses	Patient Days	445,050	11	101,335	33,090	7,533	7
8	25	Travel	Patient Days	445,050	11	100,136	33,090	7,445	8
9	26	Insurance	Patient Days	445,050	11	7,006	33,090	521	9
10	27	Employee Benefits	Patient Days	445,050	11	198,477	33,090	14,757	10
11	30	Depreciation	Patient Days	445,050	11	6,916	33,090	514	11
12	35	Equipment Rental	Patient Days	445,050	11	6,218	33,090	462	12
13	31	Amortization	Patient Days	445,050	11	1,246	33,090	93	13
14	30	Depreciation	Patient Days	445,050	11	18,376	33,090	1,366	14
15	32	Interest	Patient Days	445,050	11	32,071	33,090	2,385	15
16	33	Real Estate Taxes	Patient Days	445,050	11	18,130	33,090	1,348	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,363,852	\$ 720,831	\$ 101,404	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		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 VILLA REALTY, LLC						\$	\$			\$	1						
2	CAPMARK		X	MORTGAGE	\$32,733.40	2/28/06	3,414,100	3,353,068	2/28/41	5.3500	200,834	2						
3	LOAN COSTS		X	LOAN COSTS	W/O OVER LOAN		100,218	94,969			2,863	3						
4												4						
5												5						
Working Capital																		
6	DR TOM KLEIN		X				79,500				13,709	6						
7	ROBERT KAPLAN		X				260,977				13,049	7						
8												8						
9	TOTAL Facility Related				\$32,733.40		\$ 3,854,795	\$ 3,448,037			\$ 230,455	9						
B. Non-Facility Related*																		
10	INTEREST INCOME										(25)	10						
11												11						
12	ALLOCATION FROM PLATINUM		X								2,385	12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ 2,360	14						
15	TOTALS (line 9+line14)						\$ 3,854,795	\$ 3,448,037			\$ 232,815	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 20,564 Line # 32

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

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

Facility Name & ID Number MORTON VILLA CARE CENTER# 0045518 Report Period Beginning: 01/01/07Ending: 12/31/07

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2006 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	34,540	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.)			\$	35,433	2
3. Under or (over) accrual (line 2 minus line 1).			\$	893	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	36,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	36,893	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:					
2002	<u>31,211</u>	<u>8</u>			
2003	<u>31,596</u>	<u>9</u>			
2004	<u>33,702</u>	<u>10</u>			
2005	<u>34,540</u>	<u>11</u>			
2006	<u>35,433</u>	<u>12</u>			
			FOR BHF USE ONLY		
			13	FROM R. E. TAX STATEMENT FOR 2006 \$	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:** 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 VILLA CARE CENTER COUNTY TAZEWELL

FACILITY IDPH LICENSE NUMBER 0045518

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>06-06-29-301-010</u>	<u>NURSING HOME</u>	\$ <u>35,433.20</u>	\$ <u>35,433.20</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>35,433.20</u>	\$ <u>35,433.20</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 VILLA CARE CENTER

0045518 Report Period Beginning:

01/01/07 Ending:

12/31/07

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,769 B. General Construction Type: Exterior BRICK Frame STEEL 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>159,149</u>	1
2					2
3	TOTALS			\$ <u>159,149</u>	3

Facility Name & ID Number MORTON VILLA CARE CENTER

0045518

Report Period Beginning:

01/01/07

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		\$ 2,399,586	\$ 87,258	27.5	\$ 87,258	\$	\$ 119,104	4
5											5
6											6
7											7
8		RELATED PARTY ALLOC				614		614			8
		Improvement Type**									
9		MIXING VALVES / REGULATOR BOARD		2001	1,701	62	27.5	62		424	9
10		WINDOWS		2001	1,528	56	27.5	56		438	10
11		PATIO REPAIR		2001	3,550	129	27.5	129		930	11
12		EMPLOYEE DOOR KEYPADS		2002	4,303	156	27.5	156		910	12
13		ROOF REPAIR		2002	3,620	132	27.5	132		829	13
14		PARKING BLOCKS		2002	9,000	327	27.5	327		2,091	14
15		PAINTING / WALLPAPER		2002	15,914	579	27.5	579		3,463	15
16		HEATING & AIR		2002	2,022	74	27.5	74		443	16
17		HEATING & AIR		2003	4,581	167	27.5	167		741	17
18		STEEL COUNTER FIRE DOOR		2003	1,862	68	27.5	68		413	18
19		WATER HEATER		2004	4,918	179	27.5	179		619	19
20		CARPET, TILE, BLINDS, TOILETS		2005	5,438	198	27.5	198		486	20
21		AIR CONDITIONER		2005	950	35	27.5	35		84	21
22		SPRINKLERS		2006	3,840	140	27.5	140		204	22
23		INSTALLED NEW DRIP-EDGE AND GAF ROOF		2006	4,862	177	27.5	177		258	23
24		FLOORING IN FRONT LOBBY AND FRONT HALLWAYS		2006	36,410	1,324	27.5	1,324		1,931	24
25		AIR CONDITIONER		2006	2,145	78	27.5	78		114	25
26		LANDSCAPING		2006	10,000	667	15	667		1,000	26
27		INSTALLATION OF IRRIGATION SYSTEM		2006	10,300	375	27.5	375		546	27
28		SHOWER ROOMS		2007	55,000	1,917		1,833	(84)	1,833	28
29		CALL CORDS - 12 ROOMS		2007	1,319	264		121	(143)	121	29
30		FURNITURE		2007	13,185	2,637		1,209	(1,428)	1,209	30
31		ADDL SHOWER ROOM WORK		2007	3,600	93		98	5	98	31
32		INSTALL & PROV OF EXHAUST		2007	3,825	99		104	5	104	32
33		16 CHESTS		2007	3,997	799		200	(599)	200	33
34		DRAPERY PANELS		2007	2,794	559		200	(359)	200	34
35		PARKING LOT PAVEMENT & PATCH		2007	3,725	186		93	(93)	93	35
36		REMODEL BREAK DOWN		2007	8,660	118		105	(13)	105	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number MORTON VILLA CARE CENTER

0045518

Report Period Beginning:

01/01/07

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	INSPECT & REPAIR ROOF	2007	\$ 20,000	\$ 273		\$ 242	\$ (31)	\$ 242	37
38	CHECK & REPAIR PLUMBING	2007	20,000	212		242	30	242	38
39	RHEEM 5 TON ROOFTOP UNIT	2007	5,950	45		54	9	54	39
40	PTAC UNITS	2007	1,830	14		11	(3)	11	40
41	PTAC UNITS	2007	1,600	7		10	3	10	41
42	SIDEWALKS	2007	10,000	500			(500)		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)		\$ 2,682,015	\$ 100,514		\$ 97,313	\$ (3,201)	\$ 139,550	70

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

Facility Name & ID Number MORTON VILLA CARE CENTER # 0045518 Report Period Beginning: 01/01/07 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	\$ 113,660	\$ 21,018	\$ 11,366	\$ (9,652)	10	\$ 37,135	71
72	Current Year Purchases	19,887	3,978	1,324	(2,654)	10	1,324	72
73	Fully Depreciated Assets							73
74	RELATED PARTY ALLOC		109,561	109,561				74
75	TOTALS	\$ 133,547	\$ 134,557	\$ 122,251	\$ (12,306)		\$ 38,459	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)	\$ 2,974,711	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 235,071	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 219,564	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (15,507)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 178,009	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

10. Effective dates of current rental agreement:

Beginning 07/18/01

Ending 07/17/16

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.	<u> </u> /2008	\$ <u> </u>
13.	<u> </u> /2009	\$ <u> </u>
14.	<u> </u> /2010	\$ <u> </u>

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: \$ 56,003 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			\$	\$	17
18			<u>N/A</u>		18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

Facility Name & ID Number MORTON VILLA CARE CENTER # 0045518 Report Period Beginning: 01/01/07 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)	
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				124,554		124,554	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	39-2					12,407		12,407	13
14	TOTAL			\$		\$	\$ 136,961		\$ 136,961	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 VILLA CARE CENTER**

0045518

Report Period Beginning: **01/01/07**

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*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 70,204	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>160,923</u>)	1,720,630		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	49,503		6
7	Other Prepaid Expenses	788		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>INSURANCE ESCROW DEP</u>	39,100		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,880,225	\$	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	282,430		15
16	Equipment, at Historical Cost	133,546		16
17	Accumulated Depreciation (book methods)	(111,111)		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): <u>DUE TO/FROM R/P</u>	302,394		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 607,259	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,487,484	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 279,770	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	332,477		29
30	Accrued Salaries Payable	110,520		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	36,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accrued Expenses</u>	37,101		36
37	<u>Due Others & Advance Billing</u>	1,700,003		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,495,871	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,495,871	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (8,387)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,487,484	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 581,334	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 581,334	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(589,718)	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) ROUNDING	(3)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (589,721)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (8,387)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number MORTON VILLA CARE CENTER

0045518

Report Period Beginning: 01/01/07

Ending: 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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,739,288	1
2	Discounts and Allowances for all Levels	(228,718)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,510,570	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	888,537	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 888,537	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	180,205	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,149	19
20	Radiology and X-Ray	2,380	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 188,734	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	25	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 25	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	1,619	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,619	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,589,485	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	820,818	31
32	Health Care	2,114,323	32
33	General Administration	1,401,836	33
B. Capital Expense			
34	Ownership	647,436	34
C. Ancillary Expense			
35	Special Cost Centers	136,961	35
36	Provider Participation Fee	57,829	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,179,203	40
41	Income before Income Taxes (line 30 minus line 40)**	(589,718)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (589,718)	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 VILLA CARE CENTER**

0045518

Report Period Beginning: **01/01/07**

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	1,289	1,432	\$ 49,611	\$ 34.64	1
2	Assistant Director of Nursing	1,065	1,416	42,358	29.91	2
3	Registered Nurses	6,356	7,707	212,514	27.57	3
4	Licensed Practical Nurses	19,144	23,039	556,706	24.16	4
5	CNAs & Orderlies	45,797	55,065	625,792	11.36	5
6	CNA Trainees					6
7	Licensed Therapist	2,900	3,104	122,144	39.35	7
8	Rehab/Therapy Aides	10,117	11,704	259,503	22.17	8
9	Activity Director	1,891	2,050	25,829	12.60	9
10	Activity Assistants	4,211	4,927	47,821	9.71	10
11	Social Service Workers	1,816	2,008	27,216	13.55	11
12	Dietician					12
13	Food Service Supervisor	1,720	1,767	24,205	13.70	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,155	16,041	148,250	9.24	15
16	Dishwashers					16
17	Maintenance Workers	3,329	3,545	32,946	9.29	17
18	Housekeepers	10,135	11,427	113,080	9.90	18
19	Laundry	4,570	5,175	41,841	8.09	19
20	Administrator	1,924	2,041	58,019	28.43	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,836	4,614	59,564	12.91	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)	134,255	157,062	\$ 2,447,399 *	\$ 15.58	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	135	\$ 6,763	01-03	35
36	Medical Director	Monthly	12,042	09-03	36
37	Medical Records Consultant	Monthly	1,620	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,740	10-03	39
40	Physical Therapy Consultant	26	1,151	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	45	2,924	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	206	\$ 29,240		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 & ID Number **MORTON VILLA CARE CENTER**

0045518

Report Period Beginning: **01/01/07**

Ending: **12/31/07**

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	
DAWN LANE-WAGNER	ADMINISTRATOR	0	\$ 1,803	Workers' Compensation Insurance	\$ 103,562	IDPH License Fee	\$	
LISA TIPPY	ADMINISTRATOR	0	33,080	Unemployment Compensation Insurance	50,429	Advertising: Employee Recruitment	13,679	
JENNIFER DIXON	ADMINISTRATOR	0	23,136	FICA Taxes	186,241	Health Care Worker Background Check		
				Employee Health Insurance	26,457	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	1,552	
				Illinois Municipal Retirement Fund (IMRF)*		ADVERTISING & PROMO	13,327	
				401K	174	DUES & SUBSCRIPTIONS	7,505	
				EMPLOYEE BENEFITS	14,945	LICENSES	1,142	
				EMPLOYEE PHYSICAL EXAM	8,990	ALLOCATION FROM PLATINUM	214	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 58,019					
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	
HOME OFFICE		\$ 110,000				Out-of-State Travel	\$	
MANAGEMENT FEES		280,222				In-State Travel		
						Seminar Expense	3,690	
						Entertainment Expense	()	
TOTAL (agree to Schedule V, line 17, col. 3)						(agree to Sch. V, line 24, col. 8)		
(Attach a copy of any management service agreement)			\$ 390,222			TOTAL	\$ 3,690	
C. Professional Services			TOTAL					
Vendor/Payee	Type	Amount	Description	Line #	Amount			
SEE ATTACHED		\$ 208,142						
TOTAL (agree to Schedule V, line 19, column 3)								
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 208,142					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MORTON VILLA CARE CENTER

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 LTC - \$5,468
- (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. \$ _____ 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. N/A
- (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. \$ 57,829
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? 6%
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (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.