

Facility Name & ID Number MORTON TERRACE CARE CENTER# 0045500 Report Period Beginning: 1/01/08 Ending: 12/31/08

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	16,104	1
2		Skilled Pediatric (SNF/PED)			2
3	120	Intermediate (ICF)	120	43,920	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	164	TOTALS	164	60,024	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	39,576		5,572	45,148	8
9	SNF/PED					9
10	ICF		4,239		4,239	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,576	4,239	5,572	49,387	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.28%

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

NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

NONEF. 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 7/18/01 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 5,239Medicare Intermediary NGS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number **MORTON TERRACE CARE CENTER** # **0045500** Report Period Beginning: **1/01/08** Ending: **12/31/08**

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	271,943	37,414	9,456	318,813		318,813		318,813		1
2	Food Purchase		310,021		310,021		310,021	(4,695)	305,326		2
3	Housekeeping	142,260	24,209		166,469		166,469		166,469		3
4	Laundry	72,405	17,099	4,534	94,038		94,038		94,038		4
5	Heat and Other Utilities			185,422	185,422		185,422	5,190	190,612		5
6	Maintenance	49,851	77,643		127,494		127,494	6,059	133,553		6
7	Other (specify):*										7
8	TOTAL General Services	536,459	466,386	199,412	1,202,257		1,202,257	6,554	1,208,811		8
	B. Health Care and Programs										
9	Medical Director			10,527	10,527		10,527		10,527		9
10	Nursing and Medical Records	2,014,043	113,763	10,208	2,138,014		2,138,014		2,138,014		10
10a	Therapy	341,736	552	25,326	367,614		367,614		367,614		10a
11	Activities	187,354	2,297	408	190,059		190,059		190,059		11
12	Social Services	52,518		1,169	53,687		53,687		53,687		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,595,651	116,612	47,638	2,759,901		2,759,901		2,759,901		16
	C. General Administration										
17	Administrative	89,123		683,855	772,978		772,978	(204,289)	568,689		17
18	Directors Fees										18
19	Professional Services			87,589	87,589		87,589	6,768	94,357		19
20	Dues, Fees, Subscriptions & Promotions			49,548	49,548		49,548	(20,867)	28,681		20
21	Clerical & General Office Expenses	186,880	31,679	90,347	308,906		308,906	46,089	354,995		21
22	Employee Benefits & Payroll Taxes			490,060	490,060		490,060		490,060		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,867	2,867		2,867	488	3,355		24
25	Other Admin. Staff Transportation			30,355	30,355		30,355	5,108	35,463		25
26	Insurance-Prop.Liab.Malpractice			161,101	161,101		161,101	790	161,891		26
27	Other (specify):*							18,351	18,351		27
28	TOTAL General Administration	276,003	31,679	1,595,722	1,903,404		1,903,404	(147,562)	1,755,842		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,408,113	614,677	1,842,772	5,865,562		5,865,562	(141,008)	5,724,554		29

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

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

Facility Name & ID Number MORTON TERRACE CARE CENTER #0045500 Report Period Beginning: 1/01/08 Ending: 12/31/08

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			114,573	114,573	114,573	392,598	507,171				30
31	Amortization of Pre-Op. & Org.						118	118				31
32	Interest			134,641	134,641	134,641	309,551	444,192				32
33	Real Estate Taxes			75,122	75,122	75,122		75,122				33
34	Rent-Facility & Grounds			723,003	723,003	723,003	(723,003)					34
35	Rent-Equipment & Vehicles			71,478	71,478	71,478	585	72,063				35
36	Other (specify):*											36
37	TOTAL Ownership			1,118,817	1,118,817	1,118,817	(20,151)	1,098,666				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			181,796	181,796	181,796		181,796				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			91,134	91,134	91,134		91,134				42
43	Other (specify):*						(92,259)	(92,259)				43
44	TOTAL Special Cost Centers			272,930	272,930	272,930	(92,259)	180,671				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,408,113	614,677	3,234,519	7,257,309	7,257,309	(253,418)	7,003,891				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: 1/01/08

Ending: 12/31/08

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	(4,680)	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				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(15)	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	(26,304)	21		18
19	Entertainment				19
20	Contributions	(4,542)	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	(15,810)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(108)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(163,221)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (214,680)		\$	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)	(38,738)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (38,738)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (253,418)		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.

		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						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

MORTON TERRACE CARE CENTER

ID# 0045500

Report Period Beginning: 1/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	IL COUNCIL LTC-COPE	\$ (5,812)	20	1
2	MISC INCOME	(227)	21	2
3	MISC INCOME-CORPORATE NURSE REIMB	(71,680)	43	3
4	MARKETING SALARIES	(17,992)	43	4
5	MARKETING EMPLOYEE BENEFITS	(2,587)	43	5
6	TRAVEL-PH ECLIPSE	(672)	25	6
7	ADJ TO S/L DEPR	(45,257)	30	7
8	PRIOR YR DEPR ADJ	(16,755)	30	8
9	REAL ESTATE TAXES	(2,239)	33	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	(163,221)		49

STATE OF ILLINOIS

Summary A

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

0045500

Report Period Beginning:

1/01/08

Ending:

12/31/08

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	(4,695)	0	0	0	0	0	0	0	0	0	0	(4,695)	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	5,190	0	0	0	0	0	0	0	0	5,190	5
6	Maintenance	0	0	6,059	0	0	0	0	0	0	0	0	6,059	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(4,695)	0	11,249	0	6,554	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	(204,289)	0	0	0	0	0	0	0	0	(204,289)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	6,768	0	0	0	0	0	0	0	0	6,768	19
20	Fees, Subscriptions & Promotions	(21,622)	0	755	0	0	0	0	0	0	0	0	(20,867)	20
21	Clerical & General Office Expenses	(31,181)	0	77,270	0	0	0	0	0	0	0	0	46,089	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	488	0	0	0	0	0	0	0	0	488	24
25	Other Admin. Staff Transportation	(672)	0	5,780	0	0	0	0	0	0	0	0	5,108	25
26	Insurance-Prop.Liab.Malpractice	0	0	790	0	0	0	0	0	0	0	0	790	26
27	Other (specify):*	0	0	18,351	0	0	0	0	0	0	0	0	18,351	27
28	TOTAL General Administration	(53,475)	0	(94,087)	0	(147,562)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(58,170)	0	(82,838)	0	(141,008)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MORTON TERRACE CARE CENTER

0045500

Report Period Beginning:

1/01/08

Ending:

12/31/08

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	(62,012)	452,157	2,453	0	0	0	0	0	0	0	0	392,598	30
31	Amortization of Pre-Op. & Org.	0	0	118	0	0	0	0	0	0	0	0	118	31
32	Interest	0	306,555	2,996	0	0	0	0	0	0	0	0	309,551	32
33	Real Estate Taxes	(2,239)	0	2,239	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	585	0	0	0	0	0	0	0	0	585	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(64,251)	35,709	8,391	0	(20,151)	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):*	(92,259)	0	0	0	0	0	0	0	0	0	0	(92,259)	43
44	TOTAL Special Cost Centers	(92,259)	0	0	0	0	0	0	0	0	0	0	(92,259)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(214,680)	35,709	(74,447)	0	(253,418)	45							

Facility Name & ID Number MORTON TERRACE CARE CENTER

0045500

Report Period Beginning:

1/01/08

Ending:

12/31/08

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				277,204	277,204	3
4	V	32 MORTGAGE INSURANCE				25,666	25,666	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			\$ 758,712	\$ * 35,709	14

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

Facility Name & ID Number MORTON TERRACE CARE CENTER# 0045500Report Period Beginning: 1/01/08Ending: 12/31/08

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	\$ 233,000	Platinum Health Care, LLC	100.00%	\$	\$ (233,000)	15
16	V	5 Utilities		Platinum Health Care, LLC		5,190	5,190	16
17	V	6 Repairs & Maintenance		Platinum Health Care, LLC		6,059	6,059	17
18	V	17 Administrative Salary		Platinum Health Care, LLC		28,711	28,711	18
19	V	19 Professional Fees		Platinum Health Care, LLC		6,768	6,768	19
20	V	20 Fees, Subscriptions		Platinum Health Care, LLC		755	755	20
21	V	21 Clerical Salaries		Platinum Health Care, LLC		68,852	68,852	21
22	V	21 Office Expenses		Platinum Health Care, LLC		8,418	8,418	22
23	V	24 Education & Seminars		Platinum Health Care, LLC		488	488	23
24	V	25 Travel		Platinum Health Care, LLC		5,780	5,780	24
25	V	26 Insurance		Platinum Health Care, LLC		790	790	25
26	V	27 Employee Benefits		Platinum Health Care, LLC		18,351	18,351	26
27	V	30 Depreciation		Platinum Health Care, LLC		713	713	27
28	V	35 Equipment Rental		Platinum Health Care, LLC		585	585	28
29	V	31 Amortization		Platinum Health Care, LLC		118	118	29
30	V	30 Depreciation		Platinum Health Care, LLC		1,740	1,740	30
31	V	32 Interest		Platinum Health Care, LLC		2,996	2,996	31
32	V	33 Real Estate Taxes		Platinum Health Care, LLC		2,239	2,239	32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 233,000			\$ 158,553	\$ * (74,447)	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: 1/01/08 Ending: 12/31/08

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		SEE ATTACHED	3	7.50	Mgt Fees	\$ 150,285	17-3	1
2	Brian Levinson		Administrative			4	10.00	Mgt Fees	150,285	17-3	2
3	Mark Shapiro		Administrative			3	7.50	Mgt Fees	150,285	17-3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 450,855		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: 1/01/08

Ending: 12/31/08

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 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

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	522,253	12	\$ 54,883	\$ 49,387	\$ 5,190	1
2	6	Repairs & Maintenance	Patient Days	522,253	12	64,073	49,387	6,059	2
3	17	Administrative Salary	Patient Days	522,253	12	303,614	303,614	28,711	3
4	19	Professional Fees	Patient Days	522,253	12	71,566	49,387	6,768	4
5	20	Fees, Subscriptions	Patient Days	522,253	12	7,979	49,387	755	5
6	21	Clerical Salaries	Patient Days	522,253	12	728,090	728,090	68,852	6
7	21	Office Expenses	Patient Days	522,253	12	89,019	49,387	8,418	7
8	24	Education & Seminars	Patient Days	522,253	12	5,163	49,387	488	8
9	25	Travel	Patient Days	522,253	12	61,119	49,387	5,780	9
10	26	Insurance	Patient Days	522,253	12	8,354	49,387	790	10
11	27	Employee Benefits	Patient Days	522,253	12	194,056	49,387	18,351	11
12	30	Depreciation	Patient Days	522,253	12	7,547	49,387	713	12
13	35	Equipment Rental	Patient Days	522,253	12	6,184	49,387	585	13
14	31	Amortization	Patient Days	522,253	12	1,246	49,387	118	14
15	30	Depreciation	Patient Days	522,253	12	18,405	49,387	1,740	15
16	32	Interest	Patient Days	522,253	12	31,679	49,387	2,996	16
17	33	Real Estate Taxes	Patient Days	522,253	12	23,679	49,387	2,239	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,676,656	\$ 1,031,704		\$ 158,553	25

Facility Name & ID Number MORTON TERRACE CARE CENTER # 0045500 Report Period Beginning: 1/01/08 Ending: 12/31/08

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	MORTON TERRACE REALTY									1										
2			X	MORTGAGE			\$ 5,257,100		3/1/41	5.4000	277,204	2								
3				LOAN COSTS							3,685	3								
4				MORTGAGE INSURANCE							25,666	4								
5												5								
Working Capital																				
6	LASALLE BANK		X	WORKING CAPITAL				1,921,675			143,219	6								
7	DR. TOM KLEIN		X								(4,742)	7								
8	ROBERT KAPLAN		X					260,000			(3,836)	8								
9	TOTAL Facility Related						\$ 5,257,100	\$ 2,181,675			\$ 441,196	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13	Allocation from Platinum										2,996	13								
14	TOTAL Non-Facility Related						\$	\$			\$ 2,996	14								
15	TOTALS (line 9+line14)						\$ 5,257,100	\$ 2,181,675			\$ 444,192	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 25,666 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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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>69,122.26</u>	\$ <u>69,122.26</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>69,122.26</u>	\$ <u>69,122.26</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

1/01/08

Ending:

12/31/08

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	\$	\$ 328,336	4
5											5
6											6
7											7
8											8
		Improvement Type**									
9		ROOFTOP AC UNIT / CONDENSOR FAN		2001	5,040		27.5	183	183	1,329	9
10		ROOF REPAIRS		2001	1,900		27.5	69	69	505	10
11		DRY PIPE VALVE		2001	2,225		27.5	81	81	584	11
12		DOORS, LOCKS, ROOM SIGNS, WALLPAPER		2002	29,163		27.5	1,060	1,060	6,829	12
13		WALLPAPER		2002	67,200		27.5	2,444	2,444	15,973	13
14		ROOFING, PARKING LOT REPAIR		2002	40,373		27.5	1,468	1,468	9,397	14
15		WATER HEATER, AIR COMPRESSOR		2002	15,986		27.5	581	581	3,664	15
16		ROOF TOP AC, CONCRETE WORK, MIXING VALVE, CLOSERS		2003	8,894		27.5	323	323	1,763	16
17		ROOF REPAIR, CONDENSOR, STORAGE		2004	36,866		27.5	1,341	1,341	5,979	17
18		SECURITY, PAGING SYSTEM		2005	9,400		27.5	342	342	1,184	18
19		GUTTERS, EXHAUST FAN		2005	5,632		27.5	205	205	708	19
20		PATIO/WALK REPAIR		2005	1,882		15	125	125	438	20
21		CONCRETE WALK W/ REMOVALS , EXIT SIGNS		2006	6,814		15	454	454	1,022	21
22		RE-ROOF-EAST, WEST, NORTH WINGS AND MANSARD		2006	24,500		27.5	891	891	2,190	22
23		INSTALLATION OF A NEW CARRIER FURNACE		2006	7,355		27.5	267	267	657	23
24		FLOORING - LOBBY, DINING ROOM		2006	43,890		27.5	1,596	1,596	3,924	24
25		INSTALLED NEW CONDENSER D-WING (REMOVED \$2,100 CAP DE		2006			27.5			111	25
26		B WING FLOORING		2007	25,000		10	2,500	2,500	5,000	26
27											27
28											28
29		SHOWER ROOM		2007	16,990		27.5	618	618	566	29
30		C WING TILE-A.M. REMODELING-CONTRACT PMT		2007	20,000		10	2,000	2,000	3,500	30
31		BATHROOM REMODEL-A.M. REMODELING-CNTRACT PMT		2007	26,000		27.5	945	945	1,575	31
32		HOT WATER HEATER (REMOVED \$1,700 CAP DESK AUDIT 2008)		2007			10			128	32
33		WATER HEATER A WING KITCHEN (REMOVED \$1,900 CAP DESK		2007			10			143	33
34		D WING REM-A.M. REMODELING & DEC, INC-CONTRACT PMT		2007	20,000		27.5	727	727	1,212	34
35		ROOFTOP UNIT		2007	11,540		10	1,154	1,154	1,827	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:

1/01/08

Ending:

12/31/08

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-A.M. REMODELING-CONTRACT PM	2007	\$ 26,200	\$	27.5	\$ 953	\$ 953	\$ 1,509	37
38	INSTALL DRYER (RECLASS \$3,709 TO MME CAP DESK AUD	2007			10				38
39	INSTALL 3 TON SEER A/C (REMOVE \$1,750 CAP DESK AUDI	2007			5				39
40	HALL & ROOM VINYL TILES-A.M. REMODELING-CONTRAC	2007	56,790		10	5,679	5,679	8,519	40
41	DRAPES (REMOVE \$2,424 CAP DESK AUDIT 2008)	2007			5				41
42	A WING - A.M. REMODELING & DEC, INC.-CONTRACT PMT	2007	20,000		27.5	727	727	1,091	42
43	D WING -A.M. REMODELING-CONTRACT PMT	2007	28,040		27.5	1,020	1,020	1,360	43
44	E WING -A.M. REMODELING-CONTRACT PMT	2007	47,790		27.5	1,738	1,738	2,172	44
45	A WING -A.M. REMODELING-CONTRACT PMT	2007	48,540		27.5	1,765	1,765	2,059	45
46	B WING -A.M. REMODELING-CONTRACT PMT	2007	79,540		27.5	2,892	2,892	2,892	46
47	REMODEL HALL, BTY SHOP, OFFICE-CONTRACT PMT	2007	7,960		27.5	289	289	385	47
48	REMODEL VARIOUS ROOMS-A.M. REMODELING-CONTRAC	2008	5,925		27.5	198	198	198	48
49	M WING-A.M. REMODELING-CONTRACT PMT	2008	40,000		27.5	970	970	970	49
50	HOT WATER HEATER	2008	2,025		10	152	152	152	50
51	36 SHADOW BOXES	2008	1,804		27.5	33	33	33	51
52	5 SMOKE DETECTORS/INSTALLATION	2008	1,026		10	43	43	43	52
53	DINING ROOM REMODEL-A.M. REMODELING-CONTRACT	2008	9,995		27.5	151	151	151	53
54	CONCRETE RAMP	2008	4,890		15	109	109	109	54
55	FIRE WALL EXTENSION-A.M. REMODELING-CONTRACT P	2008	9,885		27.5	60	60	60	55
56	SMOKE DETECTORS	2008	2,957		10	25	25	25	56
57	FENCE	2008	5,759		15	32	32	32	57
58				73,004			(73,004)		58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Allocation from Platinum			796		796			67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,966,324	\$ 188,002		\$ 151,208	\$ (36,794)	\$ 420,304	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: 1/01/08 Ending: 12/31/08

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	\$ 179,371	\$ 18,422	\$ 15,451	\$ (2,971)		\$ 78,182	71
72	Current Year Purchases	10,654	6,392	900	(5,492)		900	72
73	Fully Depreciated Assets							73
74	Related Party Allocation		339,612	339,612				74
75	TOTALS	\$ 190,025	\$ 364,426	\$ 355,963	\$ (8,463)		\$ 79,082	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)	\$ 4,353,870	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 552,428	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 507,171	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (45,257)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 499,386	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	TOTAL				\$ _____			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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 49,291 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>	\$ _____	17
18				_____	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 TERRACE CARE CENTER # 0045500 Report Period Beginning: 1/01/08 Ending: 12/31/08

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	10a-3	hrs	\$	452	\$ 23,976	\$	452	\$ 23,976	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		24	1,350		24	1,350	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				169,028		169,028	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>Lab/X-ray</u>	39-2					12,768		12,768	13
14	TOTAL			\$	476	\$ 25,326	\$ 181,796	476	\$ 207,122	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: **1/01/08**

Ending:

12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/08**

(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	\$ 55,571	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,433,418		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	69,307		6
7	Other Prepaid Expenses	3,369		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	2,029,449		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,591,114	\$	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	852,795		15
16	Equipment, at Historical Cost	172,881		16
17	Accumulated Depreciation (book methods)	(293,842)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 731,834	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,322,948	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 506,342	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,181,675		29
30	Accrued Salaries Payable	163,123		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	72,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	Accrued Expenses	200,060		36
37	Due Others, Adv Billing	279,717		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,402,917	\$	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)	\$ 3,402,917	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,920,031	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,322,948	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,721,560	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,721,560	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	198,471	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 198,471	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,920,031	24 *

* This must agree with page 17, line 47.

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0045500

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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	\$ 5,968,428	1
2	Discounts and Allowances for all Levels	(752,015)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,216,413	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,707,403	6
7	Oxygen	851	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,708,254	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	4,680	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	189,690	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,647	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 204,017	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	71,907	28
28a	Gain on settlement (loans)	255,189	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 327,096	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,455,780	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,202,257	31
32	Health Care	2,759,901	32
33	General Administration	1,903,404	33
B. Capital Expense			
34	Ownership	1,118,817	34
C. Ancillary Expense			
35	Special Cost Centers	181,796	35
36	Provider Participation Fee	91,134	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,257,309	40
41	Income before Income Taxes (line 30 minus line 40)**	198,471	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 198,471	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 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.

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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	1,906	2,019	\$ 63,925	\$ 31.66	1
2	Assistant Director of Nursing	2,910	3,095	75,877	24.52	2
3	Registered Nurses	9,611	9,953	326,341	32.79	3
4	Licensed Practical Nurses	27,017	29,471	655,646	22.25	4
5	CNAs & Orderlies	68,599	74,545	861,677	11.56	5
6	CNA Trainees					6
7	Licensed Therapist	1,867	2,035	99,986	49.13	7
8	Rehab/Therapy Aides	8,450	8,971	241,750	26.95	8
9	Activity Director	3,879	4,360	54,026	12.39	9
10	Activity Assistants	11,990	12,940	133,328	10.30	10
11	Social Service Workers	2,974	3,382	52,518	15.53	11
12	Dietician					12
13	Food Service Supervisor	1,972	2,080	43,112	20.73	13
14	Head Cook					14
15	Cook Helpers/Assistants	24,053	25,399	228,831	9.01	15
16	Dishwashers					16
17	Maintenance Workers	3,307	3,494	49,851	14.27	17
18	Housekeepers	15,454	16,285	142,260	8.74	18
19	Laundry	6,074	6,477	72,405	11.18	19
20	Administrator	2,030	2,331	89,123	38.23	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,331	12,475	186,880	14.98	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	1,835	2,023	30,577	15.11	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	205,259	221,335	\$ 3,408,113 *	\$ 15.40	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	211	\$ 9,134	1-3	35
36	Medical Director	Monthly	10,527	9-3	36
37	Medical Records Consultant	Monthly	1,760	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Per Patient	8,448	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	7	1,169	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	218	\$ 31,038		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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
COLLEEN KAMIN	ADMINISTRATOR		\$ 86,585	Workers' Compensation Insurance	\$ 121,101	IDPH License Fee	\$	
PAMELA PORTER	ADMINISTRATOR		2,538	Unemployment Compensation Insurance	36,641	Advertising: Employee Recruitment	9,860	
				FICA Taxes	259,831	Health Care Worker Background Check	4,320	
				Employee Health Insurance	48,569	(Indicate # of checks performed <u>204</u>)		
				Employee Meals		Patient Background Checks	104	
				Illinois Municipal Retirement Fund (IMRF)*		ADVERTISING & MARKETING	15,810	
				401K	914	DUES & SUBSCRIPTIONS	8,715	
				EMPLOYEE BENEFITS-OTHER	19,309	LICENSES	5,031	
				EMPLOYEE PHYSICAL EXAMS	3,695	ALLOCATION FROM PLATINUM	755	
						Less: Public Relations Expense	()	
						Non-allowable advertising	(15,810)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 89,123	TOTAL (agree to Schedule V, line 22, col.8)	\$ 490,060	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 28,681	
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
MANAGEMENT FEES			\$ 450,855			\$	Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	2,867
							ALLOCATION FROM PLATINUM	488
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 450,855	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 3,355
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount					
SEE ATTACHED SCHEDULE			\$ 87,589					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 87,589					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MORTON TERRACE CARE CENTER

0045500

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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 \$11,493
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,586 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. \$ 91,134
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.