

Facility Name & ID Number MORTON VILLA CARE CENTER

0045518 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	106	Skilled (SNF)	106	38,796	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	38,796	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	25,796	2,766	3,672	32,234	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,796	2,766	3,672	32,234	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.09%

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 7/17/2001

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

YES Date 7/17/2001 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 _____

Medicare Intermediary _____

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 VILLA CARE CENTER # 0045518 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	184,526	15,897	11,132	211,555		211,555		211,555		1
2	Food Purchase		204,216		204,216		204,216	(857)	203,359		2
3	Housekeeping	125,451	12,106		137,557		137,557		137,557		3
4	Laundry	42,336	10,670	1,754	54,760		54,760		54,760		4
5	Heat and Other Utilities			147,579	147,579		147,579	3,387	150,966		5
6	Maintenance	29,254	155	33,533	62,942		62,942	3,955	66,897		6
7	Other (specify):*										7
8	TOTAL General Services	381,567	243,044	193,998	818,609		818,609	6,485	825,094		8
	B. Health Care and Programs										
9	Medical Director			12,742	12,742		12,742		12,742		9
10	Nursing and Medical Records	1,345,599	100,220	6,105	1,451,924		1,451,924		1,451,924		10
10a	Therapy	400,169		1,175	401,344		401,344		401,344		10a
11	Activities	70,209	500	971	71,680		71,680		71,680		11
12	Social Services	26,991		3,335	30,326		30,326		30,326		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,842,968	100,720	24,328	1,968,016		1,968,016		1,968,016		16
	C. General Administration										
17	Administrative	26,689		272,096	298,785		298,785	18,739	317,524		17
18	Directors Fees										18
19	Professional Services			105,180	105,180		105,180	4,417	109,597		19
20	Dues, Fees, Subscriptions & Promotions			41,673	41,673		41,673	(16,940)	24,733		20
21	Clerical & General Office Expenses	70,079	15,679	65,731	151,489		151,489	40,820	192,309		21
22	Employee Benefits & Payroll Taxes			463,820	463,820		463,820		463,820		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,972	4,972		4,972	319	5,291		24
25	Other Admin. Staff Transportation			24,845	24,845		24,845	3,100	27,945		25
26	Insurance-Prop.Liab.Malpractice			136,573	136,573		136,573	516	137,089		26
27	Other (specify):*							11,977	11,977		27
28	TOTAL General Administration	96,768	15,679	1,114,890	1,227,337		1,227,337	62,948	1,290,285		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,321,303	359,443	1,333,216	4,013,962		4,013,962	69,433	4,083,395		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:

1/01/08

Ending:

12/31/08

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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			113,777	113,777		113,777	122,239	236,016			30
31	Amortization of Pre-Op. & Org.							77	77			31
32	Interest			1,110	1,110		1,110	199,406	200,516			32
33	Real Estate Taxes			37,537	37,537		37,537	1,462	38,999			33
34	Rent-Facility & Grounds			490,116	490,116		490,116	(490,116)				34
35	Rent-Equipment & Vehicles			52,139	52,139		52,139	382	52,521			35
36	Other (specify):*											36
37	TOTAL Ownership			694,679	694,679		694,679	(166,550)	528,129			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			122,138	122,138		122,138		122,138			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			58,194	58,194		58,194		58,194			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			180,332	180,332		180,332		180,332			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,321,303	359,443	2,208,227	4,888,973		4,888,973	(97,117)	4,791,856			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: 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
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	(74,963)	30		9
10	Interest and Other Investment Income	(373)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(12)	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	(7,007)	21		18
19	Entertainment				19
20	Contributions	(1,368)	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	(13,722)	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	(6,464)	VAR		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (103,909)		\$	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)	6,792	VAR	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 6,792		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (97,117)		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						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 VILLA CARE CENTER

ID# 0045518

Report Period Beginning: 1/01/08

Ending: 12/31/08

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MISC INCOME	\$ (1,077)	21	1
2	IL COUNCIL LTC-COPE	(3,710)	20	2
3	VENDING INCOME	(845)	2	3
4	TRAVEL-PH ECLIPSE	(672)	25	4
5	CHARITY	(160)	21	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	(6,464)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MORTON VILLA CARE CENTER

0045518

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	(857)	0	0	0	0	0	0	0	0	0	0	(857)	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	3,387	0	0	0	0	0	0	0	0	3,387	5
6	Maintenance	0	0	3,955	0	0	0	0	0	0	0	0	3,955	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(857)	0	7,342	0	6,485	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	18,739	0	0	0	0	0	0	0	0	18,739	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	4,417	0	0	0	0	0	0	0	0	4,417	19
20	Fees, Subscriptions & Promotions	(17,432)	0	492	0	0	0	0	0	0	0	0	(16,940)	20
21	Clerical & General Office Expenses	(9,612)	0	50,432	0	0	0	0	0	0	0	0	40,820	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	319	0	0	0	0	0	0	0	0	319	24
25	Other Admin. Staff Transportation	(672)	0	3,772	0	0	0	0	0	0	0	0	3,100	25
26	Insurance-Prop.Liab.Malpractice	0	0	516	0	0	0	0	0	0	0	0	516	26
27	Other (specify):*	0	0	11,977	0	0	0	0	0	0	0	0	11,977	27
28	TOTAL General Administration	(27,716)	0	90,664	0	62,948	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(28,573)	0	98,006	0	69,433	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MORTON VILLA CARE CENTER

0045518

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 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)	
	D. Ownership													
30	Depreciation	(74,963)	195,600	1,602	0	0	0	0	0	0	0	0	122,239	30
31	Amortization of Pre-Op. & Org.	0	0	77	0	0	0	0	0	0	0	0	77	31
32	Interest	(373)	197,824	1,955	0	0	0	0	0	0	0	0	199,406	32
33	Real Estate Taxes	0	0	1,462	0	0	0	0	0	0	0	0	1,462	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	382	0	0	0	0	0	0	0	0	382	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(75,336)	(96,692)	5,478	0	(166,550)	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)	(103,909)	(96,692)	103,484	0	(97,117)	45							

Facility Name & ID Number MORTON VILLA CARE CENTER

0045518

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 RENTAL INCOME	\$ 490,116	MORTON VILLA REALTY, LLC		\$	\$ (490,116)	1
2	V	30 DEPRECIATION		MORTON VILLA REALTY, LLC		195,600	195,600	2
3	V	32 INTEREST		MORTON VILLA REALTY, LLC		194,961	194,961	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			\$ 393,424	\$ * (96,692)	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: **1/01/08**Ending: **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	\$	Platinum Health Care, LLC	100.00%	\$		15
16	V	5 Utilities		Platinum Health Care, LLC		3,387	3,387	16
17	V	6 Repairs & Maintenance		Platinum Health Care, LLC		3,955	3,955	17
18	V	17 Administrative Salary		Platinum Health Care, LLC		18,739	18,739	18
19	V	19 Professional Fees		Platinum Health Care, LLC		4,417	4,417	19
20	V	20 Fees, Subscriptions		Platinum Health Care, LLC		492	492	20
21	V	21 Clerical Salaries		Platinum Health Care, LLC		44,938	44,938	21
22	V	21 Office Expenses		Platinum Health Care, LLC		5,494	5,494	22
23	V	24 Education & Seminars		Platinum Health Care, LLC		319	319	23
24	V	25 Travel		Platinum Health Care, LLC		3,772	3,772	24
25	V	26 Insurance		Platinum Health Care, LLC		516	516	25
26	V	27 Employee Benefits		Platinum Health Care, LLC		11,977	11,977	26
27	V	30 Depreciation		Platinum Health Care, LLC		466	466	27
28	V	35 Equipment Rental		Platinum Health Care, LLC		382	382	28
29	V	31 Amortization		Platinum Health Care, LLC		77	77	29
30	V	30 Depreciation		Platinum Health Care, LLC		1,136	1,136	30
31	V	32 Interest		Platinum Health Care, LLC		1,955	1,955	31
32	V	33 Real Estate Taxes				1,462	1,462	32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 103,484	\$ * 103,484	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: 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	OWNER	Administrative	33.33	SEE ATTACHED	3	7.50	Mgt Fees	\$ 90,699	17-3	1
2	Brian Levinson	OWNER	Administrative	33.33	SEE ATTACHED	7	17.50	Mgt Fees	90,698	17-3	2
3	Mark Shapiro	OWNER	Administrative	33.33	SEE ATTACHED	3	7.50	Mgt Fees	90,699	17-3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 272,096		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: 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) 32-4100
 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	\$ 32,234	\$ 3,387	1
2	6	Repairs & Maintenance	Patient Days	522,253	12	64,073	32,234	3,955	2
3	17	Administrative Salary	Patient Days	522,253	12	303,614	32,234	18,739	3
4	19	Professional Fees	Patient Days	522,253	12	71,566	32,234	4,417	4
5	20	Fees, Subscriptions	Patient Days	522,253	12	7,979	32,234	492	5
6	21	Clerical Salaries	Patient Days	522,253	12	728,090	32,234	44,938	6
7	21	Office Expenses	Patient Days	522,253	12	89,019	32,234	5,494	7
8	24	Education & Seminars	Patient Days	522,253	12	5,163	32,234	319	8
9	25	Travel	Patient Days	522,253	12	61,119	32,234	3,772	9
10	26	Insurance	Patient Days	522,253	12	8,354	32,234	516	10
11	27	Employee Benefits	Patient Days	522,253	12	194,056	32,234	11,977	11
12	30	Depreciation	Patient Days	522,253	12	7,547	32,234	466	12
13	35	Equipment Rental	Patient Days	522,253	12	6,184	32,234	382	13
14	31	Amortization	Patient Days	522,253	12	1,246	32,234	77	14
15	30	Depreciation	Patient Days	522,253	12	18,405	32,234	1,136	15
16	32	Interest	Patient Days	522,253	12	31,679	32,234	1,955	16
17	33	Real Estate Taxes	Patient Days	522,253	12	23,679	32,234	1,462	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,676,656	\$	\$ 103,484	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
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		2/28/41	5.3500	194,961						
3	LOAN COSTS		X	LOAN COSTS	W/O OVER LOAN		100,218	3,315,531			2,863						
4											4						
5											5						
Working Capital																	
6	DR TOM KLEIN		X				79,500				1,110						
7	ROBERT KAPLAN		X				260,977	204,977									
8											8						
9	TOTAL Facility Related				\$32,733.40		\$ 3,854,795	\$ 3,520,508			\$ 198,934						
B. Non-Facility Related*																	
10	INTEREST INCOME										10						
11											11						
12	ALLOCATION FROM PLATINUM		X								1,955						
13											13						
14	TOTAL Non-Facility Related						\$	\$			\$ 1,955						
15	TOTALS (line 9+line14)						\$ 3,854,795	\$ 3,520,508			\$ 200,889						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 16,665 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 VILLA CARE CENTER COUNTY TAZEVELL

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 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>06-06-29-301-010</u>	<u>NURSING HOME</u>	\$ <u>36,337.00</u>	\$ <u>36,337.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>36,337.00</u>	\$ <u>36,337.00</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 VILLA CARE CENTER

0045518 Report Period Beginning:

1/01/08 Ending:

12/31/08

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:

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		\$ 2,399,586	\$ 87,258	27.5	\$ 87,258	\$	\$ 206,362	4
5		ADDED \$132,495 PER CAP DESK AUDIT 2008			132,495	4,818	27.5	4,818			5
6											6
7											7
8											8
		Improvement Type**									
9		MIXING VALVES / REGULATOR BOARD		2001	1,701	62	27.5	62		486	9
10		WINDOWS		2001	1,528	56	27.5	56		494	10
11		PATIO REPAIR		2001	3,550	129	27.5	129		1,059	11
12		EMPLOYEE DOOR KEYPADS		2002	4,303	156	27.5	156		1,066	12
13		ROOF REPAIR		2002	3,620	132	27.5	132		961	13
14		PARKING BLOCKS		2002	9,000	327	27.5	327		2,418	14
15		PAINTING/WALLPAPER (REMOVED \$8,299 CAP DESK AUDIT 2008)		2002	7,615	277	27.5	277		1,661	15
16		HEATING & AIR		2002	2,022	74	27.5	74		517	16
17		HEATING & AIR		2003	4,581	167	27.5	167		908	17
18		STEEL COUNTER FIRE DOOR		2003	1,862	68	27.5	68		481	18
19		WATER HEATER		2004	4,918	179	27.5	179		798	19
20		CARPET, TILE, BLINDS, TOILETS		2005	5,438	198	27.5	198		684	20
21		AIR CONDITIONER (REMOVED \$950 CAP DESK AUDIT 2008)		2005			27.5				21
22		SPRINKLERS		2006	3,840	140	27.5	140		344	22
23		INSTALLED NEW DRIP-EDGE AND GAF ROOF		2006	4,862	177	27.5	177		435	23
24		FLOORING IN FRONT LOBBY AND FRONT HALLWAYS		2006	36,410	1,324	27.5	1,324		3,255	24
25		AIR CONDITIONER (REMOVED \$2,145 CAP DESK AUDIT 2008)		2006			27.5				25
26		LANDSCAPING		2006	10,000	667	15	667		1,667	26
27		INSTALLATION OF IRRIGATION SYSTEM		2006	10,300	375	27.5	375		921	27
28		SHOWER ROOMS		2007	55,000	2,000	27.5	2,000		3,833	28
29		CALL CORDS-12 ROOMS(REMOVED \$1,319 CAP DESK AUDIT 2008)		2007			10			253	29
30		FURNITURE		2007							30
31		ADDL SHOWER ROOM WORK		2007	3,600	131	27.5	131		229	31
32		INSTALL & PROV OF EXHAUST		2007	3,825	139	27.5	139		243	32
33		16 CHESTS		2007							33
34		DRAPERY PANELS		2007	2,794	894	7	399	(495)	599	34
35		PARKING LOT PAVEMENT & PATCH		2007	3,725	354	20	186	(168)	279	35
36		REMDL BRKRM-A.M. REMODELING & DEC-CONTRACT PM		2007	8,660	315	27.5	315		420	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:

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	INSPECT & REPAIR ROOF	2007	\$ 20,000	\$ 727	27.5	\$ 727	\$	\$ 999	37
38	CHECK & REPAIR PLUMBING	2007	20,000	727	27.5	727		969	38
39	RHEEM 5 TON ROOFTOP UNIT	2007	5,950	216	27.5	216		270	39
40	PTAC UNITS	2007	1,830	67	27.5	67		78	40
41	PTAC UNITS	2007	1,600	58	27.5	58		68	41
42	SIDEWALKS	2007	10,000	950	20	500	(450)	500	42
43	IMPROVEMENTS	2008	50,000	1,591	30	1,389	(202)	1,389	43
44	2 PTAC UNITS	2008	1,800	1,215	10	150	(1,065)	150	44
45	AIR CONDITIONER UNITS	2008	2,379	1,606	10	198	(1,408)	198	45
46	B WING IMPROVEMENTS	2008	10,000	258	30	250	(8)	250	46
47	A WING BACK HALL VINYL TILE	2008	14,500	9,063	10	1,088	(7,975)	1,088	47
48	A WING REMODELING	2008	15,845	408	30	396	(12)	396	48
49	B WING VINYL TILE	2008	17,850	11,156	10	1,339	(9,817)	1,339	49
50	B WING BACK HALL HANDRAIL	2008	2,500	64	30	63	(1)	63	50
51	A WING LONG HALL REMODEL	2008	10,000	258	30	250	(8)	250	51
52	M WING REMODEL	2008	11,970	236	30	233	(3)	233	52
53	REMODEL A WING ROOMS	2008	8,960	176	30	149	(27)	149	53
54	M WING REMODEL	2008	37,025	617	30	617		617	54
55	NEW SIDEWALK	2008	4,890	2,567	15	82	(2,485)	82	55
56	FRONT OFFICE REMODEL	2008	9,965	136	30	111	(25)	111	56
57	HALLWAY REMODEL	2008	9,700	132	30	108	(24)	108	57
58	ENTRYWAY REMODEL	2008	9,975	136	30	111	(25)	111	58
59	A WING HALLWAY VINYL FLOOR	2008	9,625	5,534	10	321	(5,213)	321	59
60	2 HEATING/ AC UNITS	2008	1,672	961	5	111	(850)	111	60
61	REMODEL A WING HALLWAY	2008	29,800	316	30	248	(68)	248	61
62	A WING HALL VINYL FLOOR	2008	16,450	8,636	5	548	(8,088)	548	62
63	B WING HALL VINYL FLOOR	2008	6,895	3,620	5	230	(3,390)	230	63
64	LOBBY & TV ROOM FURNITURE	2008	1,016	533	15	11	(522)	11	64
65	B WING LONG HALL VINYL FLOOR	2008	9,702	5,094	10	81	(5,013)	81	65
66	B WING HALL REMODEL	2008	25,803	117	30	72	(45)	72	66
67	VINYL FLOOR- 6 PATIENT ROOMS	2008	10,848	5,695	10	90	(5,605)	90	67
68	REMODEL 6 PATIENT ROOMS	2008	19,110	29	30	53	24	53	68
69	ROOM 16 VINYL FLOORING	2008	1,808	949	10	15	(934)	15	69
70	TOTAL (lines 4 thru 69)		\$ 3,134,703	\$ 164,262		\$ 110,360	\$ (53,902)	\$ 241,571	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:

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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,134,703	\$ 164,262		\$ 110,360	\$ (53,902)	\$ 241,571	1
2	ROOM 16 REMODEL	2008	3,185	5	30	9	4	9	2
3	ROOM 21 VINYL FLOOR	2008	1,808	949	10		(949)		3
4	ROOM 21 REMODEL	2008	3,185	5	30		(5)		4
5	ROOM 37 & 39 VINYL FLOOR	2008	3,616	1,899	10		(1,899)		5
6	ROOM 37 & 39 REMODEL	2008	6,370	10	30		(10)		6
7	ROOM 40 & 43 VINYL FLOOR	2008	3,616	1,899	10		(1,899)		7
8	ROOM 40 & 43 REMODEL	2008	6,370	10	30		(10)		8
9	2 HEATING/ AC UNITS	2008	1,672	878	5		(878)		9
10	10 PHOTOELECTRIC SMOKE DETECTORS	2008	2,472	1,298	10	21	(1,277)	21	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	ALLOCATION FROM PLATINUM			520		520			26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,166,997	\$ 171,735		\$ 110,910	\$ (60,825)	\$ 241,601	34

**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: 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	\$ 150,727	\$ 24,238	\$ 15,073	\$ (9,165)	VAR	\$ 54,523	71
72	Current Year Purchases	16,810	9,564	609	(8,955)	VAR	609	72
73	Fully Depreciated Assets							73
74	RELATED PARTY ALLOC		109,424	109,424				74
75	TOTALS	\$ 167,537	\$ 143,226	\$ 125,106	\$ (18,120)		\$ 55,132	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)	\$ 3,493,683	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 314,961	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 236,016	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (78,945)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 296,733	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number MORTON VILLA CARE CENTER

0045518

Report Period Beginning: 1/01/08

Ending: 12/31/08

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 _____

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: \$ 52,139 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.

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				111,467		111,467	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					11,823		11,823	13
14	TOTAL			\$		\$	\$ 123,290		\$ 123,290	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: **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	\$ 67,356	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,554,140		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	52,211		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): INSURANCE ESCROW DEP.	39,100		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,712,807	\$	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	664,811		15
16	Equipment, at Historical Cost	150,356		16
17	Accumulated Depreciation (book methods)	(224,888)		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): DUE TO/FROM R/P	(113,465)		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 476,814	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,189,621	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 339,614	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	204,977		29
30	Accrued Salaries Payable	109,310		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	37,200		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	ACCRUED EXPENSES	134,651		36
37	DUE OTHERS & ADVANCE BILLING	2,094,968		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,920,720	\$	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)	\$ 2,920,720	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (731,099)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,189,621	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (8,387)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (8,387)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(722,711)	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	(1)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (722,712)	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)	\$ (731,099)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number MORTON VILLA CARE CENTER# 0045518Report Period Beginning: 1/01/08Ending: 12/31/08**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	\$ 3,541,283	1
2	Discounts and Allowances for all Levels	(838,127)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,703,156	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,222,103	6
7	Oxygen	11,673	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,233,776	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	145,223	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,521	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 154,744	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	373	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 373	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending \$845; Misc Income \$1,077	1,922	28
28a	Gain on Settlement	72,291	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 74,213	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,166,262	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	818,609	31
32	Health Care	1,968,016	32
33	General Administration	1,227,337	33
B. Capital Expense			
34	Ownership	694,679	34
C. Ancillary Expense			
35	Special Cost Centers	122,138	35
36	Provider Participation Fee	58,194	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,888,973	40
41	Income before Income Taxes (line 30 minus line 40)**	(722,711)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (722,711)	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: **1/01/08**

Ending:

12/31/08

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	1,745	1,896	\$ 62,136	\$ 32.77	1
2	Assistant Director of Nursing	2,279	2,438	55,720	22.85	2
3	Registered Nurses	4,940	5,175	130,066	25.13	3
4	Licensed Practical Nurses	21,418	21,762	512,869	23.57	4
5	CNAs & Orderlies	44,712	46,929	558,500	11.90	5
6	CNA Trainees					6
7	Licensed Therapist	2,893	3,103	119,884	38.63	7
8	Rehab/Therapy Aides	9,075	10,847	280,285	25.84	8
9	Activity Director	1,308	1,712	21,197	12.38	9
10	Activity Assistants	4,702	5,060	49,012	9.69	10
11	Social Service Workers	1,904	1,994	26,991	13.54	11
12	Dietician					12
13	Food Service Supervisor	2,506	2,601	27,417	10.54	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,329	17,338	157,109	9.06	15
16	Dishwashers					16
17	Maintenance Workers	2,988	3,117	29,254	9.39	17
18	Housekeepers	11,744	13,131	125,451	9.55	18
19	Laundry	4,046	4,661	42,336	9.08	19
20	Administrator	848	938	26,689	28.45	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,200	4,453	70,079	15.74	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	1,969	2,222	26,308	11.84	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	139,606	149,377	\$ 2,321,303 *	\$ 15.54	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	113	\$ 6,143	01-03	35
36	Medical Director	Monthly	12,742	09-03	36
37	Medical Records Consultant	Monthly	1,760	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,345	10-03	39
40	Physical Therapy Consultant	23	1,175	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	59	3,335	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	195	\$ 29,500		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

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 - \$5,855
- (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 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 531 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. \$ 58,194
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? _____
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? _____
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.