

Facility Name & ID Number MORTON VILLA CARE CENTER

0045518 Report Period Beginning: 1/1/09 Ending: 12/31/09

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	106	Skilled (SNF)	106	38,690	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	106	TOTALS	106	38,690	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	19,769		4,196	23,965	8
9	SNF/PED					9
10	ICF		3,289		3,289	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,769	3,289	4,196	27,254	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.44%

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)
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 3,581

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number **MORTON VILLA CARE CENTER** # **0045518** Report Period Beginning: **1/1/09** Ending: **12/31/09**

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	181,528	18,194	15,037	214,759		214,759		214,759		1
2	Food Purchase		210,430		210,430		210,430	(8)	210,422		2
3	Housekeeping	134,748	16,597		151,345		151,345		151,345		3
4	Laundry	39,566	13,836	678	54,080		54,080		54,080		4
5	Heat and Other Utilities			138,264	138,264		138,264	2,274	140,538		5
6	Maintenance	41,236	1,318	48,646	91,200		91,200	2,307	93,507		6
7	Other (specify):*										7
8	TOTAL General Services	397,078	260,375	202,625	860,078		860,078	4,573	864,651		8
	B. Health Care and Programs										
9	Medical Director			8,884	8,884		8,884		8,884		9
10	Nursing and Medical Records	1,276,572	122,822	6,500	1,405,894		1,405,894		1,405,894		10
10a	Therapy	463,554	39	1,852	465,445		465,445		465,445		10a
11	Activities	51,344	3,966	860	56,170		56,170		56,170		11
12	Social Services	28,793		3,176	31,969		31,969		31,969		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,820,263	126,827	21,272	1,968,362		1,968,362		1,968,362		16
	C. General Administration										
17	Administrative	71,210		167,025	238,235		238,235	(68,099)	170,136		17
18	Directors Fees										18
19	Professional Services			157,439	157,439		157,439	(2,495)	154,944		19
20	Dues, Fees, Subscriptions & Promotions			41,397	41,397		41,397	(19,768)	21,629		20
21	Clerical & General Office Expenses	109,405	20,656	61,385	191,446		191,446	36,092	227,538		21
22	Employee Benefits & Payroll Taxes			385,320	385,320		385,320		385,320		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,477	3,477		3,477	172	3,649		24
25	Other Admin. Staff Transportation			28,110	28,110		28,110	4,716	32,826		25
26	Insurance-Prop.Liab.Malpractice			173,719	173,719		173,719	(53,208)	120,511		26
27	Other (specify):*							11,227	11,227		27
28	TOTAL General Administration	180,615	20,656	1,017,872	1,219,143		1,219,143	(91,363)	1,127,780		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,397,956	407,858	1,241,769	4,047,583		4,047,583	(86,790)	3,960,793		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			121,889	121,889		121,889	137,901	259,790			30
31	Amortization of Pre-Op. & Org.							106	106			31
32	Interest							190,181	190,181			32
33	Real Estate Taxes			38,152	38,152		38,152	980	39,132			33
34	Rent-Facility & Grounds			478,380	478,380		478,380	(478,380)				34
35	Rent-Equipment & Vehicles			43,337	43,337		43,337	350	43,687			35
36	Other (specify):*											36
37	TOTAL Ownership			681,758	681,758		681,758	(148,862)	532,896			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			131,632	131,632		131,632		131,632			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			58,035	58,035		58,035		58,035			42
43	Other (specify):*							(43,747)	(43,747)			43
44	TOTAL Special Cost Centers			189,667	189,667		189,667	(43,747)	145,920			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,397,956	407,858	2,113,194	4,919,008		4,919,008	(279,399)	4,639,609			45

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

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	(59,005)	30		9
10	Interest and Other Investment Income	(6,903)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(8)	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	(53,609)	26		17
18	Fines and Penalties	(1,781)	21		18
19	Entertainment				19
20	Contributions	(2,535)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,170)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(18,678)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,059)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(48,262)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (198,010)		\$	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)	(81,389)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (81,389)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (279,399)		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.			\$		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 VILLA CARE CENTER

ID# 0045518

Report Period Beginning: 1/1/09

Ending: 12/31/09

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	MISC INCOME	\$ (1,085)	21	1
2	IL COUNCIL LTC-COPE	(1,449)	20	2
3	TRAVEL-PH ECLIPSE	(784)	25	3
4	MARKETING SALARIES	(37,691)	43	4
5	MARKETING EMPLOYEE BENEFITS	(6,056)	43	5
6	TAXES-GENERAL	(1,197)	21	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	(48,262)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MORTON VILLA CARE CENTER# 0045518

Report Period Beginning:

1/1/09

Ending:

12/31/09

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	(8)	0	0	0	0	0	0	0	0	0	0	(8)	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	2,274	0	0	0	0	0	0	0	0	2,274	5
6	Maintenance	0	0	2,307	0	0	0	0	0	0	0	0	2,307	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(8)	0	4,581	0	4,573	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	(68,099)	0	0	0	0	0	0	0	0	(68,099)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(6,170)	0	3,675	0	0	0	0	0	0	0	0	(2,495)	19
20	Fees, Subscriptions & Promotions	(20,127)	0	359	0	0	0	0	0	0	0	0	(19,768)	20
21	Clerical & General Office Expenses	(7,657)	0	43,749	0	0	0	0	0	0	0	0	36,092	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	172	0	0	0	0	0	0	0	0	172	24
25	Other Admin. Staff Transportation	(784)	0	5,500	0	0	0	0	0	0	0	0	4,716	25
26	Insurance-Prop.Liab.Malpractice	(53,609)	0	401	0	0	0	0	0	0	0	0	(53,208)	26
27	Other (specify):*	0	0	11,227	0	0	0	0	0	0	0	0	11,227	27
28	TOTAL General Administration	(88,347)	0	(3,016)	0	(91,363)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(88,355)	0	1,565	0	(86,790)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MORTON VILLA CARE CENTER# 0045518

Report Period Beginning:

1/1/09

Ending:

12/31/09

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	(59,005)	195,553	1,353	0	0	0	0	0	0	0	0	137,901	30
31	Amortization of Pre-Op. & Org.	0	0	106	0	0	0	0	0	0	0	0	106	31
32	Interest	(6,903)	195,592	1,492	0	0	0	0	0	0	0	0	190,181	32
33	Real Estate Taxes	0	0	980	0	0	0	0	0	0	0	0	980	33
34	Rent-Facility & Grounds	0	(478,380)	0	0	0	0	0	0	0	0	0	(478,380)	34
35	Rent-Equipment & Vehicles	0	0	350	0	0	0	0	0	0	0	0	350	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(65,908)	(87,235)	4,281	0	(148,862)	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):*	(43,747)	0	0	0	0	0	0	0	0	0	0	(43,747)	43
44	TOTAL Special Cost Centers	(43,747)	0	0	0	0	0	0	0	0	0	0	(43,747)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(198,010)	(87,235)	5,846	0	0	0	0	0	0	0	0	(279,399)	45

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

0045518

Report Period Beginning:

1/1/09

Ending:

12/31/09

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	\$ 478,380			\$	(478,380)	1
2	V	30 DEPRECIATION				195,553	195,553	2
3	V	32 INTEREST				192,729	192,729	3
4	V	32 AMORTIZATION-LOAN COSTS				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		\$ 478,380			\$ 391,145	\$ * (87,235)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
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	\$ 98,880	Platinum Health Care, LLC	100.00%	\$	\$(98,880)
16	V	5 Utilities		Platinum Health Care, LLC		2,274	2,274
17	V	6 Repairs & Maintenance		Platinum Health Care, LLC		2,307	2,307
18	V	17 Administrative Salary		Platinum Health Care, LLC		30,781	30,781
19	V	19 Professional Fees		Platinum Health Care, LLC		3,675	3,675
20	V	20 Fees, Subscriptions		Platinum Health Care, LLC		359	359
21	V	21 Clerical Salaries		Platinum Health Care, LLC		38,204	38,204
22	V	21 Office Expenses		Platinum Health Care, LLC		5,545	5,545
23	V	24 Education & Seminars		Platinum Health Care, LLC		172	172
24	V	25 Travel		Platinum Health Care, LLC		5,500	5,500
25	V	26 Insurance		Platinum Health Care, LLC		401	401
26	V	27 Employee Benefits		Platinum Health Care, LLC		11,227	11,227
27	V	30 Depreciation		Platinum Health Care, LLC		525	525
28	V	35 Equipment Rental		Platinum Health Care, LLC		350	350
29	V	31 Amortization		Platinum Health Care, LLC		106	106
30	V	30 Depreciation		Platinum Health Care, LLC		828	828
31	V	32 Interest		Platinum Health Care, LLC		1,492	1,492
32	V	33 Real Estate Taxes		Platinum Health Care, LLC		980	980
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 98,880			\$ 104,726	\$ * 5,846

* 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: 1/1/09 Ending: 12/31/09

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	21.68	SEE ATTACHED	2	5.00	Mgt Fees	\$ 22,715	17-3	1
2	BRIAN LEVINSON	OWNER	Administrative	21.67	SEE ATTACHED	7	17.50	Mgt Fees	22,715	17-3	2
3	MARK SHAPIRO	OWNER	Administrative	21.67	SEE ATTACHED	10	25.00	Mgt Fees	22,715	17-3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 68,145		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:

1/1/09

Ending: 12/31/09

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 Avenue
 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	606,157	15	\$ 50,576	\$ 27,254	\$ 2,274	1
2	6	Repairs & Maintenance	Patient Days	606,157	15	51,318	27,254	2,307	2
3	17	Administrative Salary	Patient Days	606,157	15	684,597	684,597	30,781	3
4	19	Professional Fees	Patient Days	606,157	15	81,733	27,254	3,675	4
5	20	Fees, Subscriptions	Patient Days	606,157	15	7,987	27,254	359	5
6	21	Clerical Salaries	Patient Days	606,157	15	849,689	849,689	38,204	6
7	21	Office Expenses	Patient Days	606,157	15	123,336	27,254	5,545	7
8	24	Education & Seminars	Patient Days	606,157	15	3,826	27,254	172	8
9	25	Travel	Patient Days	606,157	15	122,325	27,254	5,500	9
10	26	Insurance	Patient Days	606,157	15	8,909	27,254	401	10
11	27	Employee Benefits	Patient Days	606,157	15	249,694	27,254	11,227	11
12	30	Depreciation	Patient Days	606,157	15	11,677	27,254	525	12
13	35	Equipment Rental	Patient Days	606,157	15	7,792	27,254	350	13
14	31	Amortization	Patient Days	606,157	15	2,355	27,254	106	14
15	30	Depreciation	Patient Days	606,157	15	18,405	27,254	828	15
16	32	Interest	Patient Days	606,157	15	33,183	27,254	1,492	16
17	33	Real Estate Taxes	Patient Days	606,157	15	21,795	27,254	980	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,329,197	\$ 1,534,286	\$ 104,726	25

Facility Name & ID Number

MORTON VILLA CARE CENTER

0045518

Report Period Beginning:

1/1/09

Ending:

12/31/09

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										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	RELATED PARTY - MORTON VILLA REALTY, LLC				\$	\$			\$	1									
2	CAPMARK	X	MORTGAGE	\$32,733.40	2/28/06	3,414,100	3,317,715	2/28/41	5.3500	192,729									
3	LOAN COSTS	X	LOAN COSTS	W/O OVER LOAN		100,218				2,863									
4																			
5																			
Working Capital																			
6																			
7																			
8																			
9	TOTAL Facility Related			\$32,733.40	\$	3,514,318	\$ 3,317,715			\$ 195,592									
B. Non-Facility Related*																			
10	INTEREST INCOME									(6,903)									
11																			
12																			
13	Allocation from Platinum									1,492									
14	TOTAL Non-Facility Related				\$	\$				\$ (5,411)									
15	TOTALS (line 9+line14)				\$	3,514,318	\$ 3,317,715			\$ 190,181									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 16,470 Line # 32

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and

1. Real Estate Tax accrual used on 2008 report.		\$	37,200	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	38,152	2
3. Under or (over) accrual (line 2 minus line 1).		\$	952	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	37,200	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	38,152	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	33,702	8	
	2005	34,540	9	
	2006	35,433	10	
	2007	36,337	11	
	2008	38,152	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2008	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number MORTON VILLA CARE CENTER

0045518

Report Period Beginning:

1/1/09

Ending:

12/31/09

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1				\$ <u>159,149</u>	1
2					2
3	TOTALS			\$ 159,149	3

Facility Name & ID Number MORTON VILLA CARE CENTER

0045518

Report Period Beginning:

1/1/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4		2006		\$ 2,399,586	\$ 87,258	27.5	\$ 87,258	\$	\$ 293,620	4
5	ADDED \$132,495 PER CAP DESK AUDIT 2008			132,495	4,818	27.5	4,818		9,636	5
6										6
7										7
8										8
	Improvement Type**									
9	MIXING VALVES / REGULATOR BOARD		2001	1,701		27.5	62	62	548	9
10	WINDOWS		2001	1,528		27.5	56	56	550	10
11	PATIO REPAIR		2001	3,550		27.5	129	129	1,188	11
12	EMPLOYEE DOOR KEYPADS		2002	4,303		27.5	156	156	1,222	12
13	ROOF REPAIR		2002	3,620		27.5	132	132	1,093	13
14	PARKING BLOCKS		2002	9,000		27.5	327	327	2,745	14
15	PAINTING/WALLPAPER (REMOVED \$8,299 CAP DESK AUDIT 2008)		2002	7,615		27.5	277	277	1,938	15
16	HEATING & AIR		2002	2,022		27.5	74	74	591	16
17	HEATING & AIR		2003	4,581		27.5	167	167	1,075	17
18	STEEL COUNTER FIRE DOOR		2003	1,862		27.5	68	68	549	18
19	WATER HEATER		2004	4,918		27.5	179	179	977	19
20	CARPET, TILE, BLINDS, TOILETS		2005	5,438		27.5	198	198	882	20
21	AIR CONDITIONER (REMOVED \$950 CAP DESK AUDIT 2008)		2005			27.5				21
22	SPRINKLERS		2006	3,840		27.5	140	140	484	22
23	INSTALLED NEW DRIP-EDGE AND GAF ROOF		2006	4,862		27.5	177	177	612	23
24	FLOORING IN FRONT LOBBY AND FRONT HALLWAYS		2006	36,410		27.5	1,324	1,324	4,579	24
25	AIR CONDITIONER (REMOVED \$2,145 CAP DESK AUDIT 2008)		2006			27.5				25
26	LANDSCAPING		2006	10,000		15	667	667	2,334	26
27	INSTALLATION OF IRRIGATION SYSTEM		2006	10,300		27.5	375	375	1,296	27
28	SHOWER ROOMS		2007	55,000		27.5	2,000	2,000	5,833	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		27.5	131	131	360	31
32	INSTALL & PROV OF EXHAUST		2007	3,825		27.5	139	139	382	32
33	16 CHESTS		2007							33
34	DRAPERY PANELS		2007	2,794		7	399	399	998	34
35	PARKING LOT PAVEMENT & PATCH		2007	3,725		20	186	186	465	35
36	REMDL BRKRM-A.M. REMODELING & DEC-CONTRACT PM		2007	8,660		27.5	315		735	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:

1/1/09

Ending:

12/31/09

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	\$	27.5	\$ 727	\$ 727	\$ 1,726	37
38	CHECK & REPAIR PLUMBING	2007	20,000		27.5	727	727	1,696	38
39	RHEEM 5 TON ROOFTOP UNIT	2007	5,950		27.5	216	216	486	39
40	PTAC UNITS	2007	1,830		27.5	67	67	145	40
41	PTAC UNITS	2007	1,600		27.5	58	58	126	41
42	SIDEWALKS	2007	10,000		20	500	500	1,000	42
43	A&B WING HALLWAYS/RES. RMS-A.M. REMODELING-CON	2008	50,000		30	1,667	1,667	3,056	43
44	2 PTAC UNITS	2008	1,800		10	180	180	330	44
45	AIR CONDITIONER UNITS	2008	2,379		10	238	238	436	45
46	B WING -A.M. REMODELING-CONTRACT PMT	2008	10,000		30	333	333	583	46
47	A WING BACK HALL VINYL TILE-A.M. REMODELING-CON	2008	14,500		10	1,450	1,450	2,538	47
48	A WING DRYWALL -A.M. REMODELING-CONTRACT PMT	2008	15,845		30	528	528	924	48
49	B WING LONG/ BACK HALLS-VINYL TILE-A.M. REMODEL	2008	17,850		10	1,785	1,785	3,124	49
50	B WING BACK HALL DRYWALL-A.M. REMODELING-CONTR	2008	2,500		30	83	83	146	50
51	A WING LONG HALL -A.M. REMODELING-CONTRACT PMT	2008	10,000		30	333	333	583	51
52	M WING -A.M. REMODELING-CONTRACT PMT	2008	11,970		30	399	399	632	52
53	A WING ROOMS -A.M. REMODELING-CONTRACT PMT	2008	8,960		30	299	299	448	53
54	M WING HALLWAY -A.M. REMODELING-CONTRACT PMT	2008	37,025		30	1,234	1,234	1,851	54
55	NEW SIDEWALK - JACKSON & SONS CONCRETE	2008	4,890		15	326	326	408	55
56	FRONT OFFICE -A.M. REMODELING-CONTRACT PMT	2008	9,965		30	332	332	443	56
57	A&B WING HALLWAY -A.M. REMODELING-CONTRACT PM	2008	9,700		30	323	323	431	57
58	ENTRYWAY -A.M. REMODELING-CONTRACT PMT	2008	9,975		30	333	333	444	58
59	A WING HALLWAY VINYL FLOOR	2008	9,625		10	963	963	1,284	59
60	2 HEATING/ AC UNITS (REMOVED \$1,672 CAP DESK AUDIT	2008			5				60
61	A WING HALLWAY-A.M. REMODELING-CONTRACT PMT	2008	29,800		30	993	993	1,241	61
62	A WING HALL VINYL FLOOR-A.M. REMODELING-CONTR	2008	16,450		5	3,290	3,290	3,838	62
63	B WING HALL VINYL FLOOR-A.M. REMODELING-CONTR	2008	6,895		5	1,379	1,379	1,609	63
64	LOBBY & TV ROOM FURNITURE (REMOVED \$1,016 CAP DI	2008			15				64
65	B WING LONG HALL VINYL FLOOR-A.M. REMODEL-CONTR	2008	9,702		10	970	970	1,051	65
66	B WING HALL -A.M. REMODELING-CONTRACT PMT	2008	25,803		30	860	860	932	66
67	VINYL FLOOR- 6 PATIENT ROOMS-A.M. REMODEL-CONTR	2008	10,848		10	1,085	1,085	1,175	67
68	6 PATIENT ROOMS -A.M. REMODELING-CONTRACT PMT	2008	19,110		30	637	637	690	68
69	ROOM 16 VINYL FLOORING -A.M. REMODELING-CONTR I	2008	1,808		10	181	181	196	69
70	TOTAL (lines 4 thru 69)		\$ 3,132,015	\$ 92,076		\$ 122,250	\$ 29,859	\$ 368,517	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:

1/1/09

Ending:

12/31/09

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	
1	Totals from Page 12A, Carried Forward		\$ 3,132,015	\$ 92,076		\$ 122,250	\$ 30,174	\$ 368,517	1
2	ROOM 16 REMODEL -A.M. REMODELING-CONTRACT PMT	2008	3,185		30	106	106	115	2
3	ROOM 21 VINYL FLOOR -A.M. REM (REMOVED \$1,808 CAP	2008			10				3
4	ROOM 21 REMODEL -A.M. REMODELING-CONTRACT PMT	2008	3,185		30	106	106	106	4
5	ROOM 37 & 39 VINYL FLOOR-A.M. REMODELING-CONTR	2008	3,616		10	362	362	362	5
6	ROOM 37 & 39 -A.M. REMODELING-CONTRACT PMT	2008	6,370		30	212	212	212	6
7	ROOM 40 & 43 VINYL FLOOR-A.M. REMODELING-CONTR	2008	3,616		10	362	362	362	7
8	ROOM 40 & 43 -A.M. REMODELING-CONTRACT PMT	2008	6,370		30	212	212	212	8
9	2 HEATING/ AC UNITS	2008	1,672		5	334	334	334	9
10	10 PHOTOELECTRIC SMOKE DET (REMOVED 2,472 CAP DI	2008			10				10
11	ROOM 46 & 53 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	212	212	212	11
12	ROOM 51 & 55 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	212	212	212	12
13	BATHROOM 1-11-16-21 REMODEL-CONTRACT PMT-A.M. R	2009	9,480		30	316	316	316	13
14	ROOM 47 & 49 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	212	212	212	14
15	2 HEATING AIR UNITS	2009	1,720		5	344	344	344	15
16	ROOM 4 & 5 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	212	212	212	16
17	BATHROOM 23-26-37-39 REMODEL-CONTRACT PMT-A.M. I	2009	9,480		30	290	290	290	17
18	ROOM 30 & 32 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	195	195	195	18
19	ROOM 6 & 33 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	195	195	195	19
20	BATHROOM 27-29-40-43 REMODEL-CONTRACT PMT-A.M. I	2009	9,480		30	290	290	290	20
21	ASBESTOS INSPECTION	2009	1,882		10	173	173	173	21
22	ROOM 34 & 35 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	195	195	195	22
23	BATHROOM 46-51-53-55 REMODEL-CONTRACT PMT-A.M. I	2009	9,480		30	290	290	290	23
24	ROOM 42 & 44 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	195	195	195	24
25	BATHROOM 30-32-47-49 REMODEL-CONTRACT PMT-A.M. I	2009	9,480		30	263	263	263	25
26	ROOM 36 & 38 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	177	177	177	26
27	ROOM 48 & 52 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	177	177	177	27
28	BATHROOM 4-5-6-33 REMODEL-CONTRACT PMT-A.M. REM	2009	9,480		30	263	263	263	28
29	ROOM 41 & 24 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	159	159	159	29
30	BATHROOM 34-35-42-44 REMODEL-CONTRACT PMT-A.M. I	2009	6,370		30	159	159	159	30
31	ROOM 22 & 25 REMODEL-CONTRACT-A.M. REMODELING	2009	9,480		30	237	237	237	31
32	BATHROOM 36-38-48-52 REMODEL-CONTRACT PMT-A.M. I	2009	9,480		30	237	237	237	32
33	BATHROOM 45-14-56-12 REMODEL-CONTRACT PMT-A.M. I	2009	9,480		30	237	237	237	33
34	TOTAL (lines 1 thru 33)		\$ 3,325,391	\$ 92,076		\$ 129,184	\$ 37,108	\$ 375,460	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:

1/1/09

Ending:

12/31/09

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	
1	Totals from Page 12B, Carried Forward		\$ 3,325,391	\$ 92,076		\$ 129,184	\$ 37,108	\$ 375,460	1
2	BATHROOM 22-24-25-41 REMODEL-CONTRACT PMT-A.M. I	2009	9,480		30	237	237	237	2
3	ROOM 45 & 14 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	159	159	159	3
4	CONSTRUCTION ON BACK PATIO-SLAB-JACKER CONSTR	2009	975		30	22	22	22	4
5	ROOM 56 & 12 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	142	142	142	5
6	BATHROOM 7-18-28 REMODEL-CONTRACT PMT-A.M. REM	2009	7,110		30	158	158	158	6
7	3 HEAT/AIR UNITS & 1 AIR/HEAT SLEEVE UNIT	2009	2,624		5	306	306	306	7
8	ROOM 7 REMODEL-CONTRACT-A.M. REMODELING	2009	3,185		30	62	62	62	8
9	BATHROOM 2-3-15-19 REMODEL-CONTRACT PMT-A.M. RE	2009	9,480		30	184	184	184	9
10	ROOM 28 & 18 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	124	124	124	10
11	BATHROOM 9-10-50-54 REMODEL-CONTRACT PMT-A.M. R	2009	9,480		30	184	184	184	11
12	RELOCATE WALK IN COOLER CONDENSOR UNIT	2009	1,900		5	190	190	190	12
13	ROOM 2 & 3 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	106	106	106	13
14	RAISE SLAB E & SE CORNER OF BLDG-SLAB-JACKER CON	2009	495		20	12	12	12	14
15	ROOM 15 & 19 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	106	106	106	15
16	ADD'L SLABS RAISED-SLAB-JACKER CONSTRUCTION	2009	200		20	4	4	4	16
17	ROOF REPAIR-MARK'S CONSTRUCTION ENTERPRISE	2009	29,900		27.5	453	453	453	17
18	ROOM 50 & 54 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	88	88	88	18
19									19
20	ROOM 9 & 10 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	88	88	88	20
21	WINDOW REPLACEMENT-AMERICAN SIDING	2009	3,000		30	29	29	29	21
22	ROOM 13 & 17 REMODEL-CONTRACT-A.M. REMODELING	2009	6,370		30	71	71	71	22
23	THERAPY RM/FRONT OFFICE-REPAIR WATER DAMAAGE	2009	9,325		27.5	113	113	113	23
24	WINDOW REPLACEMENT-CONTRACT-A.M. REMODELING	2009	17,600		30	122	122	122	24
25	2 HEATING AIR UNITS	2009	1,760		5	29	29	29	25
26	33 NEW REPLACEMENT WINDOWS-A.M. REMODELING	2009	4,125		30	11	11	11	26
27	ROOM 8 REMODEL-CONTRACT-A.M. REMODELING	2009	4,993		30	14	14	14	27
28	BATHROOM 8-13-17 REMODEL-CONTRACT PMT-A.M. REM	2009	7,100		30	20	20	20	28
29	VINYL FLOOR ROOM 46,53,51,55-CONTRACT-A.M. REMODI	2009	7,232		10	723	723	723	29
30	VINYL FLOOR ROOM 47,49-CONTRACT-A.M. REMODELINI	2009	3,616		10	362	362	362	30
31	VINYL FLOOR ROOM 4,5-CONTRACT-A.M. REMODELING	2009	3,616		10	362	362	362	31
32	VINYL FLOOR ROOM 30,32-CONTRACT-A.M. REMODELINI	2009	3,616		10	331	331	331	32
33	VINYL FLOOR ROOM 6,33-CONTRACT-A.M. REMODELING	2009	3,616		10	331	331	331	33
34	TOTAL (lines 1 thru 33)		\$ 3,520,779	\$ 92,076		\$ 134,327	\$ 42,251	\$ 380,603	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:

1/1/09

Ending:

12/31/09

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	
1	Totals from Page 12C, Carried Forward		\$ 3,520,779	\$ 92,076		\$ 134,327	\$ 42,251	\$ 380,603	1
2	VINYL FLOOR ROOM 34,35-CONTRACT-A.M. REMODELIN	2009	3,616		10	331	331	331	2
3	VINYL FLOOR ROOM 42,44-CONTRACT-A.M. REMODELIN	2009	3,616		10	331	331	331	3
4	VINYL FLOOR ROOM 36,28-CONTRACT-A.M. REMODELIN	2009	3,616		10	301	301	301	4
5	VINYL FLOOR ROOM 48,52-CONTRACT-A.M. REMODELIN	2009	3,616		10	301	301	301	5
6	VINYL FLOOR ROOM 41,24-CONTRACT-A.M. REMODELIN	2009	3,616		10	271	271	271	6
7	VINYL FLOOR ROOM 34,35&42,44-CONTRACT-A.M. REMODELIN	2009	3,616		10	271	271	271	7
8	VINYL FLOOR ROOM 45,14-CONTRACT-A.M. REMODELIN	2009	3,616		10	271	271	271	8
9	VINYL FLOOR ROOM 56,12-CONTRACT-A.M. REMODELIN	2009	3,616		10	241	241	241	9
10	VINYL FLOOR ROOM 2,3-CONTRACT-A.M. REMODELING	2009	3,616		10	181	181	181	10
11	VINYL FLOOR ROOM 15,16-CONTRACT-A.M. REMODELING	2009	3,616		10	181	181	181	11
12	VINYL FLOOR ROOM 50,54-CONTRACT-A.M. REMODELING	2009	3,616		10	151	151	151	12
13	VINYL FLOOR ROOM 9,10-CONTRACT-A.M. REMODELING	2009	3,616		10	151	151	151	13
14	VINYL FLOOR ROOM 13,17-CONTRACT-A.M. REMODELING	2009	3,616		10	121	121	121	14
15	VINYL FLOOR ROOM 7-CONTRACT-A.M. REMODELING	2009	1,808		10	105	105	105	15
16	VINYL FLOOR ROOM 28,18-CONTRACT-A.M. REMODELIN	2009	3,616		10	211	211	211	16
17				98,278			(98,278)		17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29	Allocation from Platinum			543		543			29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,573,211	\$ 190,897		\$ 138,289	\$ (52,608)	\$ 384,022	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 167,537	\$ 17,623	\$ 16,623	\$ (1,000)		\$ 71,756	71
72	Current Year Purchases	9,979	5,988	591	(5,397)		591	72
73	Fully Depreciated Assets							73
74			104,287	104,287				74
75	TOTALS	\$ 177,516	\$ 127,898	\$ 121,501	\$ (6,397)		\$ 72,347	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)	\$ 3,909,876	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 318,795	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 259,790	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (59,005)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 456,369	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

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: \$ 38,292 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</u>	\$ <u>5,045</u>	17
18			<u>SCHEDULE</u>		18
19					19
20					20
21	TOTAL		\$ _____	\$ <u>5,045</u>	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____/2010 \$ _____

13. _____/2011 \$ _____

14. _____/2012 \$ _____

* 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	10a-3	hrs		36	1,800		36	1,800	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				121,556		121,556	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>RT</u>	10a-3				52			52	12
13	Other (specify): <u>Lab</u>	39-2					10,076		10,076	13
14	TOTAL			\$	36	\$ 1,852	\$ 131,632	36	\$ 133,484	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/09**

(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	\$ 78,781	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	702,519		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	49,785		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)	\$ 870,185	\$	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	1,077,993		15
16	Equipment, at Historical Cost	160,336		16
17	Accumulated Depreciation (book methods)	(346,777)		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	(614,846)		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 276,706	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,146,891	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 451,244	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	156,977		29
30	Accrued Salaries Payable	125,210		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	63,163		36
37	DUE OTHERS, ADV BILLING	1,258,851		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,092,645	\$	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)	\$ 2,092,645	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (945,754)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,146,891	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (731,099)	1
2	Restatements (describe):		2
3	ROUNDING	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (731,100)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(214,654)	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)	\$ (214,654)	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)	\$ (945,754)	24 *

* This must agree with page 17, line 47.

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

0045518

Report Period Beginning: **1/1/09**

Ending: **12/31/09**

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	\$ 3,517,048	1
2	Discounts and Allowances for all Levels	(601,797)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,915,251	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,578,758	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,578,758	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	194,668	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,689	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 202,357	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	6,903	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,903	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC INC	1,085	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,085	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,704,354	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	860,078	31
32	Health Care	1,968,362	32
33	General Administration	1,219,143	33
B. Capital Expense			
34	Ownership	681,758	34
C. Ancillary Expense			
35	Special Cost Centers	131,632	35
36	Provider Participation Fee	58,035	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,919,008	40
41	Income before Income Taxes (line 30 minus line 40)**	(214,654)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (214,654)	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 filed 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:

1/1/09

Ending:

12/31/09

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	1,846	1,990	\$ 58,812	\$ 29.55	1
2	Assistant Director of Nursing	2,782	2,878	75,905	26.37	2
3	Registered Nurses	4,762	4,885	133,878	27.41	3
4	Licensed Practical Nurses	17,713	17,963	446,340	24.85	4
5	CNAs & Orderlies	46,102	47,518	535,678	11.27	5
6	CNA Trainees					6
7	Licensed Therapist	2,374	2,623	93,300	35.57	7
8	Rehab/Therapy Aides	12,789	14,031	370,254	26.39	8
9	Activity Director	1,404	1,570	21,060	13.41	9
10	Activity Assistants	3,379	3,407	30,284	8.89	10
11	Social Service Workers	2,024	2,130	28,793	13.52	11
12	Dietician					12
13	Food Service Supervisor	2,372	2,635	29,830	11.32	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,974	15,487	151,698	9.80	15
16	Dishwashers					16
17	Maintenance Workers	2,768	2,874	41,236	14.35	17
18	Housekeepers	15,797	16,915	134,748	7.97	18
19	Laundry	3,714	4,186	39,566	9.45	19
20	Administrator	1,560	1,624	71,210	43.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,681	6,837	109,405	16.00	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	1,960	2,171	25,959	11.96	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	145,001	151,724	\$ 2,397,956 *	\$ 15.80	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	108	\$ 5,940	01-03	35
36	Medical Director	Monthly	8,884	09-03	36
37	Medical Records Consultant	Quarterly	1,760	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,740	10-03	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	55	3,176	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	163	\$ 24,500		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

0045518

Report Period Beginning:

1/1/09

Ending: 12/31/09

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 \$7,855
- (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 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 179 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. \$ 58,035
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. \$ 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: _____
- (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.