

		FOR BHF USE					

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2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0052142</u></p> <p>Facility Name: <u>Morton Terrace H & R Centre</u></p> <p>Address: <u>191 E Queenwood Road</u> <u>Morton</u> <u>61550</u> Number City Zip Code</p> <p>County: <u>Tazewell</u></p> <p>Telephone Number: <u>(309) 266-5331</u> Fax # <u>(309) 266-9376</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>1/1/2013</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236-1111</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/14</u> to <u>12/31/14</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td rowspan="2">Paid Preparer</td> <td>(Type or Print Name) _____</td> </tr> <tr> <td>(Title) _____</td> </tr> <tr> <td></td> <td>(Signed) _____</td> </tr> <tr> <td></td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) <u>Cary Drazner, C.P.A.</u></td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td> </tr> </table> <p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) _____	(Title) _____		(Signed) _____		(Date) _____		(Print Name and Title) <u>Cary Drazner, C.P.A.</u>		(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>		(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>
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Facility Name & ID Number Morton Terrace H & R Centre

0052142 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

N/A

	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	<u>46</u>	Skilled (SNF)	<u>46</u>	<u>16,790</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>120</u>	Intermediate (ICF)	<u>120</u>	<u>43,800</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>166</u>	TOTALS	<u>166</u>	<u>60,590</u>	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	<u>10,368</u>		<u>3,558</u>	<u>13,926</u>	8
9	SNF/PED					9
10	ICF	<u>15,427</u>	<u>6,504</u>	<u>924</u>	<u>22,855</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>25,795</u>	<u>6,504</u>	<u>4,482</u>	<u>36,781</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.70%

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 1/1/2013

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

YES Date 7/18/2001 NO

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

YES NO If YES, enter number of beds certified 46 and days of care provided 2,839

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: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number

Morton Terrace H & R Centre

0052142

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	217,706	54,510	11,767	283,983		283,983	56	284,039		1
2	Food Purchase		193,360		193,360		193,360	(618)	192,742		2
3	Housekeeping	159,794	33,498		193,292		193,292	956	194,248		3
4	Laundry	85,451	21,592	1,210	108,253		108,253		108,253		4
5	Heat and Other Utilities			150,567	150,567		150,567	(5,388)	145,179		5
6	Maintenance	27,246	17,381	64,054	108,681		108,681	(43,749)	64,932		6
7	Other (specify):*										7
8	TOTAL General Services	490,197	320,341	227,598	1,038,136		1,038,136	(48,743)	989,393		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000	5,520	11,520		9
10	Nursing and Medical Records	2,150,026	91,839	210,826	2,452,691		2,452,691	14,641	2,467,332		10
10a	Therapy	24,470		25,145	49,615		49,615		49,615		10a
11	Activities	156,207	7,005	1,375	164,587		164,587	10	164,597		11
12	Social Services	100,247		4,536	104,783		104,783	3,748	108,531		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							3,707	3,707		15
16	TOTAL Health Care and Programs	2,430,950	98,844	247,882	2,777,676		2,777,676	27,626	2,805,302		16
	C. General Administration										
17	Administrative	76,843		77,477	154,320		154,320	53,094	207,414		17
18	Directors Fees										18
19	Professional Services			294,594	294,594	(2,188)	292,406	(190,495)	101,911		19
20	Dues, Fees, Subscriptions & Promotions			93,063	93,063		93,063	(24,182)	68,881		20
21	Clerical & General Office Expenses	103,643	23,059	500,798	627,500		627,500	(272,848)	354,652		21
22	Employee Benefits & Payroll Taxes			558,017	558,017		558,017		558,017		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,150	1,150		1,150	111	1,261		24
25	Other Admin. Staff Transportation			16,549	16,549		16,549	2,723	19,272		25
26	Insurance-Prop.Liab.Malpractice			94,083	94,083		94,083	491	94,574		26
27	Other (specify):*							30,793	30,793		27
28	TOTAL General Administration	180,486	23,059	1,635,731	1,839,276	(2,188)	1,837,088	(400,313)	1,436,774		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,101,633	442,244	2,111,211	5,655,088	(2,188)	5,652,900	(421,430)	5,231,469		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 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			15,938	15,938		15,938	181,665	197,603			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			56,173	56,173		56,173	663,134	719,307			32
33	Real Estate Taxes			81,882	81,882	2,188	84,070	2,930	87,000			33
34	Rent-Facility & Grounds			726,691	726,691		726,691	(726,691)				34
35	Rent-Equipment & Vehicles			14,949	14,949		14,949	303	15,252			35
36	Other (specify):*			(358,849)	(358,849)		(358,849)	358,849				36
37	TOTAL Ownership			536,784	536,784	2,188	538,972	480,190	1,019,162			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		122,760	523,613	646,373		646,373		646,373			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			296,069	296,069		296,069		296,069			42
43	Other (specify):*			49,044	49,044		49,044	(49,044)	0			43
44	TOTAL Special Cost Centers		122,760	868,726	991,486		991,486	(49,044)	942,442			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,101,633	565,004	3,516,721	7,183,358		7,183,358	9,716	7,193,074			45

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

Facility Name & ID Number Morton Terrace H & R Centre

0052142

Report Period Beginning: 01/01/14

Ending: 12/31/14

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	(6,798)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(228,652)	30		9
10	Interest and Other Investment Income	(3,019)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(342)	02		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	(21,096)	21		18
19	Entertainment				19
20	Contributions	(2,289)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(297,081)	21		24
25	Fund Raising, Advertising and Promotional	(19,582)	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	(230,574)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (809,433)		\$	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)	819,149		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 819,149		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 9,716		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 Terrace H & R CentreID# 0052142Report Period Beginning: 01/01/14Ending: 12/31/14

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Medicare Sequestration	\$ (20,524)	21	1
2	Marketing Consultant	(31,480)	43	2
3	Bank Charges	(15,623)	21	3
4	Marketing Salaries	(17,564)	43	4
5	Theft & Loss	(107)	21	5
6	Misc. Income	(255)	21	6
7	Amortization Expense - Building Co.	(89,073)	31	7
8	PPA - Building Co.	(272)	21	8
9	Food Rebate	(276)	02	9
10	PAC Dues	(5,215)	20	10
11	Additional R&M	17,368	06	11
12	Capitalized R&M	(64,853)	06	12
13	Non-Allowable Legal	(2,700)	19	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		(230,574)	49

Morton Terrace H & R Centre

Report Period Beginning: 01/01/14
 Ending: 12/31/14

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32

82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Morton Terrace H & R Centre# 0052142

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary			56									56	1
2	Food Purchase	(618)											(618)	2
3	Housekeeping			956									956	3
4	Laundry													4
5	Heat and Other Utilities	(6,798)		1,012	398								(5,388)	5
6	Maintenance	(47,485)		3,582	154								(43,749)	6
7	Other (specify):*													7
8	TOTAL General Services	(54,901)		5,606	552								(48,743)	8
	B. Health Care and Programs													
9	Medical Director			5,520									5,520	9
10	Nursing and Medical Records			14,641									14,641	10
10a	Therapy													10a
11	Activities			10									10	11
12	Social Services			3,748									3,748	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			3,707									3,707	15
16	TOTAL Health Care and Programs			27,626									27,626	16
	C. General Administration													
17	Administrative			81,509		(28,415)							53,094	17
18	Directors Fees													18
19	Professional Services	(2,700)		(188,355)	334	226							(190,495)	19
20	Fees, Subscriptions & Promotions	(27,086)		2,895	9								(24,182)	20
21	Clerical & General Office Expenses	(354,958)	272	81,781	29	28							(272,848)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			111									111	24
25	Other Admin. Staff Transportation			691		2,032							2,723	25
26	Insurance-Prop.Liab.Malpractice			311	180								491	26
27	Other (specify):*			30,793									30,793	27
28	TOTAL General Administration	(384,744)	272	9,736	552	(26,129)							(400,313)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(439,645)	272	42,968	1,104	(26,129)							(421,430)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Morton Terrace H & R Centre# 0052142

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	(228,652)	404,170	4,349	1,798								181,665	30
31	Amortization of Pre-Op. & Org.	(89,073)	89,073											31
32	Interest	(3,019)	662,447	91	3,615								663,134	32
33	Real Estate Taxes				2,930								2,930	33
34	Rent-Facility & Grounds		(726,691)	12,907	(12,907)								(726,691)	34
35	Rent-Equipment & Vehicles			303									303	35
36	Other (specify):*		358,849										358,849	36
37	TOTAL Ownership	(320,744)	787,848	17,650	(4,564)								480,190	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(49,044)											(49,044)	43
44	TOTAL Special Cost Centers	(49,044)											(49,044)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(809,433)	788,120	60,618	(3,460)	(26,129)							9,716	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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)	
1	V	34 Rental Income	\$ 726,691	MTHRC Realty, LLC	100.00%	\$	(726,691)	1
2	V	31 Amortization Expense		MTHRC Realty, LLC	100.00%	89,073	89,073	2
3	V	30 Depreciation Expense		MTHRC Realty, LLC	100.00%	404,170	404,170	3
4	V	32 Interest Expense		MTHRC Realty, LLC	100.00%	662,447	662,447	4
5	V	21 Prior Period Adjustment		MTHRC Realty, LLC	100.00%	272	272	5
6	V	36 Loss on Interco Loan		MTHRC Realty, LLC	100.00%	358,849	358,849	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 726,691			\$ 1,514,811	\$ * 788,120	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	1 <u>DIETARY</u>	\$	<u>MANAGCARE, INC.</u>	100.00%	\$ 56	\$	56	15
16	V	3 <u>HOUSEKEEPING</u>		<u>MANAGCARE, INC.</u>	100.00%	956		956	16
17	V	5 <u>UTILITIES</u>		<u>MANAGCARE, INC.</u>	100.00%	1,012		1,012	17
18	V	6 <u>REPAIRS AND MAINT.</u>		<u>MANAGCARE, INC.</u>	100.00%	3,582		3,582	18
19	V	9 <u>MEDICAL DIRECTOR</u>		<u>MANAGCARE, INC.</u>	100.00%	5,520		5,520	19
20	V	10 <u>NURSING SALARIES/CONSULTANT</u>	24,375	<u>MANAGCARE, INC.</u>	100.00%	39,016		14,641	20
21	V	11 <u>ACTIVITIES</u>		<u>MANAGCARE, INC.</u>	100.00%	10		10	21
22	V	12 <u>SOCIAL SERVICE SALARIES</u>		<u>MANAGCARE, INC.</u>	100.00%	3,748		3,748	22
23	V	15 <u>NURSING EMP BENS & PR TAXES</u>		<u>MANAGCARE, INC.</u>	100.00%	3,707		3,707	23
24	V	17 <u>ADMINISTRATIVE SALARIES</u>		<u>MANAGCARE, INC.</u>	100.00%	81,509		81,509	24
25	V	19 <u>PROFESSIONAL FEES</u>		<u>MANAGCARE, INC.</u>	100.00%	3,478		3,478	25
26	V	20 <u>FEES, SUBSCRIPTIONS</u>		<u>MANAGCARE, INC.</u>	100.00%	2,895		2,895	26
27	V	21 <u>CLERICAL AND GENERAL SALARIES</u>		<u>MANAGCARE, INC.</u>	100.00%	76,239		76,239	27
28	V	21 <u>CLERICAL AND GENERAL EXP</u>		<u>MANAGCARE, INC.</u>	100.00%	5,542		5,542	28
29	V	24 <u>SEMINARS</u>		<u>MANAGCARE, INC.</u>	100.00%	111		111	29
30	V	25 <u>ADMIN. STAFF TRANS.</u>		<u>MANAGCARE, INC.</u>	100.00%	691		691	30
31	V	26 <u>INSURANCE</u>		<u>MANAGCARE, INC.</u>	100.00%	311		311	31
32	V	27 <u>GEN. ADMIN. EMP. BEN.</u>		<u>MANAGCARE, INC.</u>	100.00%	30,793		30,793	32
33	V	30 <u>DEPRECIATION</u>		<u>MANAGCARE, INC.</u>	100.00%	4,349		4,349	33
34	V	32 <u>INTEREST EXPENSE</u>		<u>MANAGCARE, INC.</u>	100.00%	91		91	34
35	V	34 <u>RENT - BUILDING (RELATED)</u>		<u>MANAGCARE, INC.</u>	100.00%	12,907		12,907	35
36	V	35 <u>EQUIPMENT RENTAL</u>		<u>MANAGCARE, INC.</u>	100.00%	303		303	36
37	V	19 <u>ADMINISTRATIVE COSULTANT</u>	52,393	<u>MANAGCARE, INC.</u>	100.00%			(52,393)	37
38	V	19 <u>BOOKKEEPING</u>	139,440	<u>MANAGCARE, INC.</u>	100.00%			(139,440)	38
39	Total		\$ 216,208			\$ 276,826	\$ *	60,618	39

* 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	5 UTILITIES	\$	4600 TOUHY, LLC	100.00%	\$ 398	\$	398	15
16	V	6 REPAIRS & MAINT.		4600 TOUHY, LLC	100.00%	154		154	16
17	V	19 PROFESSIONAL FEES		4600 TOUHY, LLC	100.00%	334		334	17
18	V	20 FEES, SUBSCRIPTIONS		4600 TOUHY, LLC	100.00%	9		9	18
19	V	21 CLERICAL & GENERAL		4600 TOUHY, LLC	100.00%	29		29	19
20	V	26 INSURANCE		4600 TOUHY, LLC	100.00%	180		180	20
21	V	30 DEPRECIATION		4600 TOUHY, LLC	100.00%	1,798		1,798	21
22	V	32 INTEREST EXPENSE		4600 TOUHY, LLC	100.00%	3,615		3,615	22
23	V	33 REAL ESTATE TAXES		4600 TOUHY, LLC	100.00%	2,930		2,930	23
24	V								24
25	V	34 RENT	12,907	4600 TOUHY, LLC	100.00%			(12,907)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 12,907			\$ 9,447	\$ *	(3,460)	39

* 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 ADMINISTRATIVE SALARY - NATH	\$	TETRAD MANAGEMENT, LLC	100.00%	\$ 15,096	\$	15,096	15
16	V	17 ADMINISTRATIVE SALARY - JOSH DAVIS		TETRAD MANAGEMENT, LLC	100.00%	15,096		15,096	16
17	V	17 ADMINISTRATIVE SALARY - MOSHE DAVIS		TETRAD MANAGEMENT, LLC	100.00%	15,096		15,096	17
18	V	19 PROFESSIONAL FEES		TETRAD MANAGEMENT, LLC	100.00%	226		226	18
19	V	21 OFFICE EXPENSE		TETRAD MANAGEMENT, LLC	100.00%	28		28	19
20	V	25 TRAVEL		TETRAD MANAGEMENT, LLC	100.00%	2,032		2,032	20
21	V	17 ADMINISTRATIVE FEES		TETRAD MANAGEMENT, LLC	100.00%	3,774		3,774	21
22	V	17 MANAGEMENT FEES	77,477	TETRAD MANAGEMENT, LLC	100.00%			(77,477)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 77,477			\$ 51,348	\$ *	(26,129)	39

* 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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* 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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* 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: 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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* 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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* 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: 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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* 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: 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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

Facility Name & ID Number

Morton Terrace H & R Centre

0052142

Report Period Beginning:

01/01/14

Ending:

12/31/14

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Central Illinois Operations LLC	99.99%	BRIGHTVIEW CARE CENTER, INC	CHICAGO	MTHRC Realty, LLC	MORTON	BUILDING CO.	1
2	Morton Terrace Health And Rehab Centre LLC	0.01%	LAKE SHORE HEALTHCARE & REHABILITATION CENTRE,LLC	CHICAGO	4600 Touhy LLC	LINCOLNWOOD	BUILDING CO.	2
3			MAYFIELD CARE CENTER, INC.	CHICAGO	MANAGCARE, INC.	LINCOLNWOOD	BOOKKEEPING	3
4			CAPITOL HEALTHCARE & REHABILITATION CENTRE	SPRINGFIELD, IL	INTERCARE, LTD. C/O MANAG	LINCOLNWOOD	MANAGEMENT CO.	4
5			COLONIAL HEALTHCARE & REHABILITATION CENTRE	PRINCETON, IL	TETRAD MANAGEMENT, LLC	LINCOLNWOOD	MANAGEMENT CO.	5
6			THE HEIGHTS HEALTHCARE & REHABILITATION CENTRE	PEORIA HEIGHTS, IL				6
7			MORTON VILLA HEALTHCARE & REHABILITATION CENTRE	MORTON, IL				7
8			MID AMERICA CARE CENTER, LLC	CHICAGO				8
9			RIVERSHORES HEALTHCARE 7 REHABILITATION CENTRE	MASEILLES, IL				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

Facility Name & ID Number

Morton Terrace H & R Centre

0052142

Report Period Beginning:

01/01/14

Ending:

12/31/14

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Morton Terrace H & R Centre # 0052142 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Moshe Davis	Relative	Mgmt /Admin	0.00%	See Attached	3.32	7.55%	Alloc Fee	\$ 15,096	17-7	1
2	Yehoshua Davis	Relative	Mgmt /Admin	0.00%	See Attached	3.62	7.54%	Alloc Fee	15,096	17-7	2
3	Nesanel Davis	Relative	Mgmt /Admin	0.00%	See Attached	3.62	7.54%	Alloc Fee	15,096	17-7	3
4	Eli Davis	Relative	Mgmt /Admin	0.00%	See Attached	3.02	7.55%	Alloc Fee	3,774	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 49,062		13

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

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

Facility Name & ID Number Morton Terrace H & R Centre

0052142 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Morton Terrace H & R Centre

0052142

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization MANAGCARE, INC.
 Street Address 4600 W. TOUHY AVENUE, SUITE 200
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (773) 463-1313
 Fax Number (773) 463- 5311

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIETARY	PATIENT DAYS	487,280	10	\$ 748	\$ 36,781	\$ 56	1	
2	3	HOUSEKEEPING	PATIENT DAYS	487,280	10	12,659	36,781	956	2	
3	5	UTILITIES	PATIENT DAYS	487,280	10	13,409	36,781	1,012	3	
4	6	REPAIRS AND MAINT.	PATIENT DAYS	487,280	10	47,454	36,781	3,582	4	
5	9	MEDICAL DIRECTOR	PATIENT DAYS	487,280	10	73,125	36,781	5,520	5	
6	10	NURSING SALARIES	PATIENT DAYS	487,280	10	516,890	516,890	36,781	39,016	6
7	11	ACTIVITIES	PATIENT DAYS	487,280	10	136	36,781	10	7	
8	12	SOCIAL SERVICE SALARIES	PATIENT DAYS	487,280	10	49,654	49,654	36,781	3,748	8
9	15	NURSING EMP BENS & PR TA	PATIENT DAYS	487,280	10	49,107	36,781	3,707	9	
10	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	487,280	10	1,079,846	1,079,846	36,781	81,509	10
11	19	PROFESSIONAL FEES	PATIENT DAYS	487,280	10	46,077	36,781	3,478	11	
12	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	487,280	10	38,354	36,781	2,895	12	
13	21	CLERICAL AND GENERAL SA	PATIENT DAYS	487,280	10	1,010,032	1,010,032	36,781	76,239	13
14	21	CLERICAL AND GENERAL EX	PATIENT DAYS	487,280	10	73,419	36,781	5,542	14	
15	24	SEMINARS	PATIENT DAYS	487,280	10	1,473	36,781	111	15	
16	25	ADMIN. STAFF TRANS.	PATIENT DAYS	487,280	10	9,155	36,781	691	16	
17	26	INSURANCE	PATIENT DAYS	487,280	10	4,123	36,781	311	17	
18	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	487,280	10	407,944	36,781	30,793	18	
19	30	DEPRECIATION	PATIENT DAYS	487,280	10	57,614	36,781	4,349	19	
20	32	INTEREST EXPENSE	PATIENT DAYS	487,280	10	1,200	36,781	91	20	
21	34	RENT - BUILDING (RELATED)	PATIENT DAYS	487,280	10	171,000	36,781	12,907	21	
22	35	EQUIPMENT RENTAL	PATIENT DAYS	487,280	10	4,015	36,781	303	22	
23									23	
24									24	
25	TOTALS				\$ 3,667,434	\$ 2,656,422	\$ 276,826		25	

Facility Name & ID Number Morton Terrace H & R Centre

0052142

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization 4600 TOUHY, LLC
 Street Address 4600 W. TOUHY AVENUE, SUITE 200
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (773) 463-1313
 Fax Number (773) 463- 5311

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	MNGCR. PATIENT DAYS 487,280	10	\$ 5,277	\$	36,781	\$ 398	1
2	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS 487,280	10	2,035		36,781	154	2
3	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS 487,280	10	4,429		36,781	334	3
4	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS 487,280	10	148		36,781	9	4
5	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS 487,280	10	391		36,781	29	5
6	26	INSURANCE	MNGCR. PATIENT DAYS 487,280	10	2,388		36,781	180	6
7	30	DEPRECIATION	MNGCR. PATIENT DAYS 487,280	10	23,819		36,781	1,798	7
8	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS 487,280	10	47,891		36,781	3,615	8
9	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS 487,280	10	38,818		36,781	2,930	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	TOTALS				\$ 125,196	\$		\$ 9,447	25

Facility Name & ID Number Morton Terrace H & R Centre

0052142 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization TETRAD MANAGEMENT, LLC
 Street Address 4600 W. TOUHY AVENUE, SUITE 200
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (773) 463-1313
 Fax Number (773) 463- 5311

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE SALARY - PATIENT DAYS	487,280	10	\$ 200,000	\$ 200,000	36,781	\$ 15,096	1
2	17	ADMINISTRATIVE SALARY - PATIENT DAYS	487,280	10	200,000	200,000	36,781	15,096	2
3	17	ADMINISTRATIVE SALARY - PATIENT DAYS	487,280	10	200,000	200,000	36,781	15,096	3
4	19	PROFESSIONAL FEES PATIENT DAYS	487,280	10	3,000		36,781	226	4
5	21	OFFICE EXPENSE PATIENT DAYS	487,280	10	374		36,781	28	5
6	25	TRAVEL PATIENT DAYS	487,280	10	26,914		36,781	2,032	6
7	17	ADMINISTRATIVE FEES PATIENT DAYS	487,280	10	50,000		36,781	3,774	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	TOTALS				\$ 680,288	\$ 600,000		\$ 51,348	25

Facility Name & ID Number Morton Terrace H & R Centre

0052142 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Morton Terrace H & R Centre

0052142 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Morton Terrace H & R Centre

0052142 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Morton Terrace H & R Centre

0052142 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Morton Terrace H & R Centre

0052142 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Morton Terrace H & R Centre

0052142 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	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**					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	Private Bank		X	Note payable			\$	\$			\$ 518,689					
2	Greystone		X	Note payable							143,758					
3																
4																
5																
Working Capital																
6	Private Bank		X	Loan Payable							51,885					
7	Other Interest		X								4,288					
8	See Supplemental Schedule										3,706					
9	TOTAL Facility Related						\$	\$			\$ 722,326					
B. Non-Facility Related*																
10	Interest Income		X								(3,019)					
11																
12																
13																
14	TOTAL Non-Facility Related						\$	\$			\$ (3,019)					
15	TOTALS (line 9+line14)						\$	\$			\$ 719,307					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # _____

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

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

Facility Name & ID Number Morton Terrace H & R Centre

0052142

Report Period Beginning:

01/01/14

Ending:

12/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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**					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							\$	\$			\$					
2																
3																
4																
5																
6																
7	TOTAL Long-Term															
	Working Capital															
8	Allocated from Managcare		X				\$	\$			\$ 91					
9	Allocated from 4600 Touhy, LLC		X								3,615					
10																
11																
12																
13																
14	TOTAL Working Capital										3,706					
	B. Non-Facility Related*															
15							\$	\$			\$					
16																
17																
18																
19																
20	TOTAL Non-Facility Related															

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

SEE ACCOUNTANTS' COMPILATION REPORT

** 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 bill must accompany the cost report.													
1. Real Estate Tax accrual used on 2013 report.		\$	<u>82,199</u>		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.)		\$	<u>83,207</u>		2										
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>1,008</u>		3										
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>83,805</u>		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.)		\$	<u>2,188</u>		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.		\$	<u>87,001</u>		7										
Real Estate Tax History:															
Real Estate Tax Bill for Calendar Year:	2009	_____	8	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2013 \$ _____</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$ _____</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$ _____</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$ _____</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2013 \$ _____	14	PLUS APPEAL COST FROM LINE 5 \$ _____	15	LESS REFUND FROM LINE 6 \$ _____	16	AMOUNT TO USE FOR RATE CALCULATION \$ _____
FOR BHF USE ONLY															
13	FROM R. E. TAX STATEMENT FOR 2013 \$ _____														
14	PLUS APPEAL COST FROM LINE 5 \$ _____														
15	LESS REFUND FROM LINE 6 \$ _____														
16	AMOUNT TO USE FOR RATE CALCULATION \$ _____														
	2010	_____	9												
	2011	_____	10												
	2012	<u>80,587</u>	11												
	2013	<u>80,277</u>	12												
<u>2014 Accrual = \$80,277 x 1.04 = \$80,805</u>															
<u>Alloated from 4600 Touhy, LLC \$2,930</u>															

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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Morton Terrace H & R Centre COUNTY Tazewell
 FACILITY IDPH LICENSE NUMBER 0052142
 CONTACT PERSON REGARDING THIS REPORT Steve Lavenda
 TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2013 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 2013.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>06-06-29-115-003</u>	<u>Long Term Care Property</u>	\$ <u>80,276.60</u>	\$ <u>80,276.60</u>
2. <u>See Attached</u>	<u>Allocated From 4600 Touhy LLC</u>	\$ <u>84,567.54</u>	\$ <u>3,191.67</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>164,844.14</u></u>	\$ <u><u>83,468.27</u></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? X YES NO

If YES, attach an explanation and 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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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.**

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

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 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	166		2013	1971	\$ 3,724,471	\$ 404,170	39	\$ 95,499	\$ (308,671)	\$ 190,998	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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

*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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68		79,135	2,550		3,312	762	9,536	68
69			15,938			(15,938)		69
70		\$ 3,803,606	\$ 422,658		\$ 98,811	\$ (323,847)	\$ 200,534	70

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		\$ 3,803,606	\$ 422,658		\$ 98,811	\$ (323,847)	\$ 200,534	1
2	Walk-In Cooler	2013	2,868		20	191	191	319	2
3	Water Heater	2013	4,950		20	495	495	784	3
4	A/C Unit - Rheem Rknl060	2013	6,482		20	1,296	1,296	1,945	4
5	A/C Unit - Rheem Condenser	2013	3,555		20	711	711	948	5
6	Installation Of Tankless Hot Water Heater	2013	4,950		20	248	248	392	6
7	Water Heater	2013	2,785		20	139	139	139	7
8	Air Compressor	2014	3,950		20	527	527	527	8
9	Lanscaping And Fence Repairs	2014	5,500		20	275	275	275	9
10	Install New Condenser	2014	2,945		20	147	147	147	10
11	2 Furnaces Installed	2014	13,905		20	695	695	695	11
12	C Wing Furnace Replacement	2014	3,150		20	158	158	158	12
13	Install 2 Furnaces And More Coil	2014	16,500		20	825	825	825	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	TOTAL (lines 1 thru 33)		\$ 3,875,146	\$ 422,658		\$ 104,518	\$ (318,140)	\$ 207,687	34

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

Facility Name & ID Number Morton Terrace H & R Centre

0052142

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 3,875,146	\$ 422,658		\$ 104,518	\$ (318,140)	\$ 207,687	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 3,875,146	\$ 422,658		\$ 104,518	\$ (318,140)	\$ 207,687	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1		\$ 3,875,146	\$ 422,658		\$ 104,518	\$ (318,140)	\$ 207,687		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 3,875,146	\$ 422,658		\$ 104,518	\$ (318,140)	\$ 207,687		34

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

Facility Name & ID Number Morton Terrace H & R Centre

0052142

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 3,875,146	\$ 422,658		\$ 104,518	\$ (318,140)	\$ 207,687	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 3,875,146	\$ 422,658		\$ 104,518	\$ (318,140)	\$ 207,687	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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 12E, Carried Forward		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								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	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1		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 12F, Carried Forward		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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 12G, Carried Forward		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated From 4600 Touhy LLC	2012	38,757	994	20	1,292	298	3,876	3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated From Managcare	2013	651	173	20	33	(140)	65	9
10	Allocated From Managcare	2012	8,092	578	20	405	(173)	1,214	10
11									11
12	Allocated From 4600 Touhy LLC	2012	24,959	647	20	1,248	601	3,744	12
13	Allocated From 4600 Touhy LLC	2013	6,073	143	20	304	161	607	13
14	Allocated From 4600 Touhy LLC	2014	603	15	20	30	15	30	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	TOTAL (lines 1 thru 33)		\$ 79,135	\$ 2,550		\$ 3,312	\$ 762	\$ 9,536	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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 12H, Carried Forward		\$ 79,135	\$ 2,550		\$ 3,312	\$ 762	\$ 9,536	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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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	TOTAL (lines 1 thru 33)		\$ 79,135	\$ 2,550		\$ 3,312	\$ 762	\$ 9,536	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 1,555,093	\$ 3,155	\$ 86,598	\$ 83,443	10	\$ 168,875	71
72	Current Year Purchases	60,769		5,452	5,452	10	5,452	72
73	Fully Depreciated Assets	18,591				10	18,591	73
74								74
75	TOTALS	\$ 1,634,453	\$ 3,155	\$ 92,050	\$ 88,895		\$ 192,918	75

D. Vehicle Costs. (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		Allocated from Managcare	2014	\$ 9,123	\$ 442	\$ 1,035	\$ 593	5	\$ 8,342	76
77										77
78										78
79										79
80	TOTALS			\$ 9,123	\$ 442	\$ 1,035	\$ 593		\$ 8,342	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)	\$ 5,988,233	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 426,255	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 197,603	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (228,652)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 408,947	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 Terrace H & R Centre

0052142

Report Period Beginning: 01/01/14

Ending: 12/31/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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: \$ 898

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	Facility	2014 Ford Champion	\$	\$ 14,354	17
18		Challenger			18
19					19
20					20
21	TOTAL		\$	\$ 14,354	21

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

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

Facility Name & ID Number Morton Terrace H & R Centre # 0052142 Report Period Beginning: 01/01/14 Ending: 12/31/14
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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	202,925	\$		\$	202,925	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				62,737				62,737	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				215,380				215,380	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescripts					113,086			113,086	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify): <u>See Supplemental</u>						42,571	9,674			52,245	13
14	TOTAL			\$		\$	523,613	\$	122,760	\$	646,373	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Morton Terrace H & R Centre# 0052142Report Period Beginning: 01/01/14

Ending:

12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 176,496	\$	1
2	Cash-Patient Deposits	15,558		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,548,948		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	147,310		6
7	Other Prepaid Expenses	51,763		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	93,811		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,033,886	\$	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	62,278		15
16	Equipment, at Historical Cost	171,363		16
17	Accumulated Depreciation (book methods)	(22,905)		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):	292,918		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 503,654	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,537,540	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 821,513	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,558		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	183,054		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,700		31
32	Accrued Real Estate Taxes(Sch.IX-B)	83,805		32
33	Accrued Interest Payable	2,530		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	122,132		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,242,292	\$	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	See Attached Schedule	1,985,942		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,985,942	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,228,234	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (690,694)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,537,540	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (289,557)	1
2	Restatements (describe):		2
3	Rounding	4	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (289,553)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(401,141)	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)	\$ (401,141)	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)	\$ (690,694)	24 *

* This must agree with page 17, line 47.

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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,395,426	1
2	Discounts and Allowances for all Levels	(799,099)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,596,327	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,056,076	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,056,076	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	109,022	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,052	19
20	Radiology and X-Ray	1,869	20
21	Other Medical Services	6,530	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 126,473	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	3,019	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,019	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	322	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 322	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,782,217	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,038,136	31
32	Health Care	2,777,676	32
33	General Administration	1,839,276	33
B. Capital Expense			
34	Ownership	536,784	34
C. Ancillary Expense			
35	Special Cost Centers	695,417	35
36	Provider Participation Fee	296,069	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,183,358	40
41	Income before Income Taxes (line 30 minus line 40)**	(401,141)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (401,141)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,681,545	44
45	Private Pay - Net Inpatient Revenue	1,146,425	45
46	Medicare - Net Inpatient Revenue	520,217	46
47	Other-(specify) <u>Hospice</u>	140,600	47
48	Other-(specify) <u>Insurance</u>	107,540	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,596,327	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Morton Terrace H & R Centre

0052142

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	1,768	1,960	\$ 70,984	\$ 36.22	1
2	Assistant Director of Nursing	2,067	2,184	66,382	30.39	2
3	Registered Nurses	7,952	8,562	217,535	25.41	3
4	Licensed Practical Nurses	35,818	38,724	955,098	24.66	4
5	CNAs & Orderlies	63,881	68,821	801,098	11.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	950	1,160	24,470	21.09	8
9	Activity Director	2,597	3,042	44,388	14.59	9
10	Activity Assistants	9,813	10,603	111,819	10.55	10
11	Social Service Workers	5,196	5,423	97,431	17.97	11
12	Dietician					12
13	Food Service Supervisor	4,276	4,609	70,008	15.19	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,371	16,354	147,698	9.03	15
16	Dishwashers					16
17	Maintenance Workers	1,750	1,888	27,246	14.43	17
18	Housekeepers	14,989	15,973	159,794	10.00	18
19	Laundry	7,646	8,363	85,451	10.22	19
20	Administrator	1,948	2,008	76,843	38.27	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,789	7,266	103,643	14.26	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	1,942	2,165	38,929	17.98	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	246	246	2,816	11.44	33
34	TOTAL (lines 1 - 33)	184,999	199,351	\$ 3,101,633 *	\$ 15.56	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	Monthly	\$ 11,767	01-03	35
36	Medical Director	Monthly	6,000	09-03	36
37	Medical Records Consultant	Monthly	1,880	10-03	37
38	Nurse Consultant	Monthly	24,375	10-03	38
39	Pharmacist Consultant	Monthly	7,908	10-03	39
40	Physical Therapy Consultant	Monthly	910	10a-03	40
41	Occupational Therapy Consultant	Monthly	595	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,375	11-03	44
45	Social Service Consultant	73	4,536	12-03	45
46	Other(specify) <u>MDS Consultant</u>	Monthly	29,880		46
47	<u>Renal Therapy Consultant</u>	Monthly	23,640	10a-03	47
48	<u>Outside Nursing - DON</u>	Monthly	24,015	10-03	48
49	TOTAL (lines 35 - 48)	73	\$ 136,881		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	315	\$ 15,766	10-03	50
51	Licensed Practical Nurses	90	3,589	10-03	51
52	Certified Nurse Assistants/Aides	4,137	103,413	10-03	52
53	TOTAL (lines 50 - 52)	4,542	\$ 122,768		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Nicole Hibbard	Administrator	0	\$ 67,613	Workers' Compensation Insurance	\$ 64,159	IDPH License Fee	\$	
Laurie Read	Administrator	0	9,230	Unemployment Compensation Insurance	182,299	Advertising: Employee Recruitment	42,543	
				FICA Taxes	237,275	Health Care Worker Background Check (Indicate # of checks performed <u>127.9</u>)	5,371	
				Employee Health Insurance	42,637	Patient Background Checks		
				Employee Meals		Dues & Subscriptions	13,926	
				Illinois Municipal Retirement Fund (IMRF)*		Licenses & Permits	4,137	
				Other Employee Benefits	14,441	Allocated from Managcare	2,895	
				Safe Harbor Match Expense	13,605	Allocated from 4600 Touhy, LLC	9	
				Holiday Expense	3,601			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 76,843	TOTAL (agree to Schedule V, line 22, col.8)		\$ 68,881		
B. Administrative - Other							Less: Public Relations Expense ()	
Description			Amount				Non-allowable advertising ()	
Tetrad Management - Management Fees			\$ 77,477				Yellow page advertising ()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 77,477	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services							Description	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Amount	
See Attached	Legal		\$ 19,436			\$	Out-of-State Travel	
Frost, Ruttenberg & Rothblatt	Accounting		14,625					
Personnel Planners	Unemployment Consultant		13,903					
Managcare, Inc	Bookkeeping		139,440				In-State Travel	
MDI Achieve	Insurance Consultant		179					
Managcare, Inc	Administrative Consult		52,393					
Provinet Solutions	Computer Services		11,507					
Onward Consulting	IT Consulting		5,164				Seminar Expense	
FRS HC Consulting	Healthcare Consulting		1,500				1,150	
Smartlinx	Computer Services		2,698				Allocated from Managcare	
Ability	Computer Services		3,963				111	
See Supplemental Schedule			29,786					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 294,594	TOTAL		\$	Entertainment Expense () (agree to Sch. V, line 24, col. 8)	
							TOTAL	
							\$ 1,261	

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
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19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Morton Terrace H & R Centre

0052142

Report Period Beginning:

01/01/14

Ending:

12/31/14

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. IL Council on LTC \$15,802
- (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. \$ 16,346 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 296,069
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. \$ N/A 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? 100% ln 14
- 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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.