

		FOR BHF USE					

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

I. IDPH License ID Number: 0052142

Facility Name: Morton Terrace Healthcare And Rehabilitation Centre, Llc

Address: 191 East Queenwood Road Morton 61550
Number City Zip Code

County: Tazewell

Telephone Number: (309) 266-5331 Fax # (309) 266-9376

HFS ID Number:

Date of Initial License for Current Owners: 1/1/2013

Type of Ownership:

☐ VOLUNTARY,NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda Telephone Number: (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/16 to 12/31/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) _____
(Title) _____

Paid
Preparer

(Signed) _____ * _____ (Date) _____
* Subject to the attached Accountants Consulting Report
(Print Name and Title) _____
(Firm Name & Address) Marcum, LLP
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Morton Terrace Healthcare And Rehabilitation Centre, Llc

0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	46	Skilled (SNF)	46	16,836
2		Skilled Pediatric (SNF/PED)		
3	120	Intermediate (ICF)	120	43,920
4		Intermediate/DD		
5		Sheltered Care (SC)		
6		ICF/DD 16 or Less		
7	166	TOTALS	166	60,756

B. Census-For the entire report period.

1	2	3	4	5	
Level of Care	Patient Days by Level of Care and Primary Source of Payment				
	Medicaid Recipient	Private Pay	Other	Total	
8	SNF	8,991		3,011	12,002
9	SNF/PED				
10	ICF	13,377	3,649	1,571	18,597
11	ICF/DD				
12	SC				
13	DD 16 OR LESS				
14	TOTALS	22,368	3,649	4,582	30,599

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 50.36%

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 01/01/2013

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

YES

☒

Date 07/18/2001

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

1,789

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: 12/31/2016

Fiscal Year: 12/31/2016

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

STATE OF ILLINOIS

Facility Name & ID Number

Morton Terrace Healthcare And Rehabilitation

0052142

Report Period Beginning:

01/01/16

Ending:

12/31/16

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	200,016	25,589	9,935	235,540		235,540	40	235,580			1
2	Food Purchase		202,166		202,166		202,166	(241)	201,925			2
3	Housekeeping		5,534	212,403	217,937		217,937	522	218,459			3
4	Laundry		2,935	140,581	143,516		143,516		143,516			4
5	Heat and Other Utilities			168,400	168,400		168,400	(10,415)	157,985			5
6	Maintenance	35,866	13,673	84,504	134,043		134,043	(749)	133,294			6
7	Other (specify):*											7
8	TOTAL General Services	235,882	249,897	615,823	1,101,602		1,101,602	(10,844)	1,090,758			8
	B. Health Care and Programs											
9	Medical Director			13,000	13,000		13,000		13,000			9
10	Nursing and Medical Records	2,241,428	140,717	69,175	2,451,320		2,451,320	6,888	2,458,208			10
10a	Therapy	3,623			3,623		3,623		3,623			10a
11	Activities	154,008	7,803	75	161,886		161,886		161,886			11
12	Social Services	91,831		910	92,741		92,741	3,461	96,202			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							7,914	7,914			15
16	TOTAL Health Care and Programs	2,490,890	148,520	83,160	2,722,570		2,722,570	18,263	2,740,833			16
	C. General Administration											
17	Administrative	97,518		47,837	145,355		145,355	(11,429)	133,926			17
18	Directors Fees											18
19	Professional Services			299,142	299,142		299,142	(209,898)	89,244			19
20	Dues, Fees, Subscriptions & Promotions			65,004	65,004		65,004	(34,375)	30,629			20
21	Clerical & General Office Expenses	178,167	20,949	636,947	836,063		836,063	(466,243)	369,820			21
22	Employee Benefits & Payroll Taxes			452,182	452,182		452,182		452,182			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,990	1,990		1,990	587	2,577			24
25	Other Admin. Staff Transportation			15,952	15,952		15,952	2,640	18,592			25
26	Insurance-Prop.Liab.Malpractice			90,977	90,977		90,977	569	91,546			26
27	Other (specify):*							27,240	27,240			27
28	TOTAL General Administration	275,685	20,949	1,610,031	1,906,665		1,906,665	(690,908)	1,215,757			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,002,457	419,366	2,309,014	5,730,837		5,730,837	(683,489)	5,047,348			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.
 NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			44,220	44,220		44,220	233,551	277,771			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							48	48			32
33	Real Estate Taxes			78,053	78,053		78,053	2,945	80,998			33
34	Rent-Facility & Grounds			296,010	296,010		296,010	(294,642)	1,368			34
35	Rent-Equipment & Vehicles			17,141	17,141		17,141	323	17,464			35
36	Other (specify):*											36
37	TOTAL Ownership			435,424	435,424		435,424	(57,776)	377,648			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		99,714	767,507	867,221		867,221		867,221			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			295,001	295,001		295,001		295,001			42
43	Other (specify):*	4,845		29,880	34,725		34,725	(34,725)	0			43
44	TOTAL Special Cost Centers	4,845	99,714	1,092,388	1,196,947		1,196,947	(34,725)	1,162,222			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,007,302	519,080	3,836,826	7,363,208		7,363,208	(775,989)	6,587,219			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 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	(11,521)	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	232,045	30		9
10	Interest and Other Investment Income	(2,702)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(241)	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	(30,902)	21		18
19	Entertainment				19
20	Contributions	(200)	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	(474,118)	21		24
25	Fund Raising, Advertising and Promotional	(29,136)	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	(430,418)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (747,193)		\$	30

BHF USE ONLY								
48		49		50		51		52

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 Amount	2 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)	(28,796)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (28,796)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (775,989)		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 Yes	2 No	3 Amount	4 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

Report Period Beginning:

Ending:

ID#0052142

01/01/16

12/31/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Marketing Expenses	\$ (34,725)	43	1
2	Bank Charges	(6,812)	21	2
3	Theft and Loss	(16)	21	3
4	Sequestration	(21,927)	21	4
5	Miscellaneous Income	(2,437)	21	5
6	Out of Period Expense	(1,500)	21	6
7	Capitalized R&M	(2,592)	06	7
8	Non-Allowable Legal	(11,255)	19	8
9	PAC Dues	(5,308)	20	9
10	Rent for Sale Leaseback Arrangement	(296,010)	34	10
11	Non-Allowable Expense	(47,837)	17	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(430,418)		49

ID#

0052142

Report Period Beginning:

01/01/16

Ending:

12/31/16

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			49

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

X 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			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	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	DIETARY	\$	MOSAIC HEALTHCARE	100.00%	\$ 40	\$ 40	15
16	V	3	HOUSEKEEPING		MOSAIC HEALTHCARE	100.00%	522	522	16
17	V	5	UTILITIES		MOSAIC HEALTHCARE	100.00%	915	915	17
18	V	6	REPAIRS AND MAINT.		MOSAIC HEALTHCARE	100.00%	1,151	1,151	18
19	V	10	NURSING SALARIES		MOSAIC HEALTHCARE	100.00%	36,768	36,768	19
20	V	12	SOCIAL SERVICE SALARIES		MOSAIC HEALTHCARE	100.00%	3,461	3,461	20
21	V	15	NURSING EMP BENS & PR TAXES		MOSAIC HEALTHCARE	100.00%	7,914	7,914	21
22	V	17	ADMINISTRATIVE SALARIES		MOSAIC HEALTHCARE	100.00%	36,408	36,408	22
23	V	19	PROFESSIONAL FEES		MOSAIC HEALTHCARE	100.00%	1,127	1,127	23
24	V	20	FEES, SUBSCRIPTIONS		MOSAIC HEALTHCARE	100.00%	251	251	24
25	V	21	CLERICAL AND GENERAL SALARIES		MOSAIC HEALTHCARE	100.00%	66,398	66,398	25
26	V	21	CLERICAL AND GENERAL EXP		MOSAIC HEALTHCARE	100.00%	8,159	8,159	26
27	V	24	SEMINARS		MOSAIC HEALTHCARE	100.00%	119	119	27
28	V	25	ADMIN. STAFF TRANS.		MOSAIC HEALTHCARE	100.00%	355	355	28
29	V	26	INSURANCE		MOSAIC HEALTHCARE	100.00%	288	288	29
30	V	27	GEN. ADMIN. EMP. BEN.		MOSAIC HEALTHCARE	100.00%	20,224	20,224	30
31	V	34	RENT - BUILDING (RELATED)		MOSAIC HEALTHCARE	100.00%	9,927	9,927	31
32	V	35	EQUIPMENT RENTAL		MOSAIC HEALTHCARE	100.00%	323	323	32
33	V								33
34	V	19	BOOKKEEPING	58,735	MOSAIC HEALTHCARE	100.00%		(58,735)	34
35	V	19	ADMINISTRATIVE CONSULTANT	29,880	MOSAIC HEALTHCARE	100.00%		(29,880)	35
36	V	10	MDS CONSULTANT	29,880	MOSAIC HEALTHCARE	100.00%		(29,880)	36
37	V	21	OFFICE CONSULTANT	44,880	MOSAIC HEALTHCARE	100.00%		(44,880)	37
38	V								38
39	Total			\$ 163,375			\$ 194,349	\$ * 30,974	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.

☒ X

 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%	191	\$	191
16	V	6	REPAIRS & MAINT.		4600 TOUHY, LLC	100.00%	509		509
17	V	19	PROFESSIONAL FEES		4600 TOUHY, LLC	100.00%	73		73
18	V	20	FEES, SUBSCRIPTIONS		4600 TOUHY, LLC	100.00%	19		19
19	V	21	CLERICAL & GENERAL		4600 TOUHY, LLC	100.00%	13		13
20	V	26	INSURANCE		4600 TOUHY, LLC	100.00%	123		123
21	V	30	DEPRECIATION		4600 TOUHY, LLC	100.00%	1,506		1,506
22	V	32	INTEREST EXPENSE		4600 TOUHY, LLC	100.00%	2,750		2,750
23	V	33	REAL ESTATE TAXES		4600 TOUHY, LLC	100.00%	2,945		2,945
24	V								
25	V	34	RENT	9,927	4600 TOUHY, LLC	100.00%			(9,927)
26	V								
27	V								
28	V								
29	V								
30	V								
31	V								
32	V								
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$ 9,927			\$ 8,127	\$ *	(1,800)

* 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	6	MAINTENANCE & REPAIR	\$	PLATINUM BILLING SOLUTIONS	30.00%	\$ 183	\$ 183	15
16	V	19	PROFESSIONAL SERVICES		PLATINUM BILLING SOLUTIONS	30.00%	966	966	16
17	V	21	CLERICAL & GENERAL		PLATINUM BILLING SOLUTIONS	30.00%	6,466	6,466	17
18	V	21	CLERICAL & GENERAL- SALARY		PLATINUM BILLING SOLUTIONS	30.00%	35,314	35,314	18
19	V	24	BUSINESS SEMINAR		PLATINUM BILLING SOLUTIONS	30.00%	469	469	19
20	V	25	AUTO & TRAVEL		PLATINUM BILLING SOLUTIONS	30.00%	2,285	2,285	20
21	V	26	INSURANCE		PLATINUM BILLING SOLUTIONS	30.00%	159	159	21
22	V	27	EMPLOYEE BENEFITS/TAXES		PLATINUM BILLING SOLUTIONS	30.00%	7,016	7,016	22
23	V	34	RENT		PLATINUM BILLING SOLUTIONS	30.00%	1,368	1,368	23
24	V								24
25	V	19	AR MANAGEMENT SERVICES	112,195	PLATINUM BILLING SOLUTIONS	30.00%		(112,195)	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			\$ 112,195			\$ 54,225	\$ * (57,970)	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:	
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:	
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

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%	MOSAIC OF BEACON	CHICAGO	4600 Touhy LLC	LINCOLNWOOD	BUILDING CO.	1
2	MORTON TERRACE HEALTH AND REHAB CENTER	0.01%	MOSAIC OF LAKE SHORE	CHICAGO	MOSAIC HC	LINCOLNWOOD	BOOKKEEPING	2
3			MOSAIC OF MAYFIELD	CHICAGO	TETRAD MANAGEMENT, LLC	LINCOLNWOOD	MANAGEMENT CO.	3
4			MOSAIC OF SPRINGFIELD	SPRINGFIELD, IL	PLATINUM BILLING SOLUTION	LAKEWOOD, NJ	BILLING SERVICES	4
5			COLONIAL HEALTHCARE & REHABILITATION CENTRE	PRINCETON, IL	Worthy Insurance Group, LLC	Skokie	Insurance Company	5
6			THE HEIGHTS HEALTHCARE & REHABILITATION CENTRE	PEORIA HEIGHTS, IL				6
7			MORTON VILLA HEALTHCARE & REHABILITATION CENTRE	MORTON, IL				7
8			MOSAIC OF UPTOWN	CHICAGO				8
9			RIVERSHORES HEALTHCARE & 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

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

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	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		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 Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 MOSAIC HEALTHCARE
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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	1	DIETARY	PATIENT DAYS	483,176	10	\$ 625	\$	30,599	\$ 40	1
2	3	HOUSEKEEPING	PATIENT DAYS	483,176	10	8,235		30,599	522	2
3	5	UTILITIES	PATIENT DAYS	483,176	10	14,454		30,599	915	3
4	6	REPAIRS AND MAINT.	PATIENT DAYS	483,176	10	18,179		30,599	1,151	4
5	10	NURSING SALARIES	PATIENT DAYS	483,176	10	580,592	580,592	30,599	36,768	5
6	12	SOCIAL SERVICE SALARIES	PATIENT DAYS	483,176	10	54,655	54,655	30,599	3,461	6
7	15	NURSING EMP BENS & PR TAX	PATIENT DAYS	483,176	10	124,964		30,599	7,914	7
8	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	483,176	10	574,906	574,906	30,599	36,408	8
9	19	PROFESSIONAL FEES	PATIENT DAYS	483,176	10	17,800		30,599	1,127	9
10	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	483,176	10	3,962		30,599	251	10
11	21	CLERICAL AND GENERAL SAL	PATIENT DAYS	483,176	10	1,048,463	1,048,463	30,599	66,398	11
12	21	CLERICAL AND GENERAL EX	PATIENT DAYS	483,176	10	128,829		30,599	8,159	12
13	24	SEMINARS	PATIENT DAYS	483,176	10	1,876		30,599	119	13
14	25	ADMIN. STAFF TRANS.	PATIENT DAYS	483,176	10	5,603		30,599	355	14
15	26	INSURANCE	PATIENT DAYS	483,176	10	4,543		30,599	288	15
16	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	483,176	10	319,345		30,599	20,224	16
17	34	RENT - BUILDING (RELATED)	PATIENT DAYS	483,176	10	156,750		30,599	9,927	17
18	35	EQUIPMENT RENTAL	PATIENT DAYS	483,176	10	5,104		30,599	323	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,068,885	\$ 2,258,616		\$ 194,349	25

Facility Name & ID Number Morton Terrace Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	UTILITIES	MNGCR. PATIENT DAYS	483,176	10	3,010		30,599	191	1
2	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS	483,176	10	8,036		30,599	509	2
3	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS	483,176	10	1,150		30,599	73	3
4	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS	483,176	10	293		30,599	19	4
5	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS	483,176	10	209		30,599	13	5
6	26	INSURANCE	MNGCR. PATIENT DAYS	483,176	10	1,941		30,599	123	6
7	30	DEPRECIATION	MNGCR. PATIENT DAYS	483,176	10	23,779		30,599	1,506	7
8	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS	483,176	10	43,419		30,599	2,750	8
9	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS	483,176	10	46,499		30,599	2,945	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					\$ 128,334	\$		\$ 8,127	25

Facility Name & ID Number Morton Terrace Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization PLATINUM BILLING SOLUTIONS
Street Address 1100 TOWBIN AVENUE, UNIT C
City / State / Zip Code LAKEWOOD, NJ 08701
Phone Number (773) 463-1313
Fax Number (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINTENANCE & REPAIR	PATIENT DAYS	483,176	10	\$ 2,885	\$	30,599	\$ 183	1
2	19	PROFESSIONAL SERVICES	PATIENT DAYS	483,176	10	15,260		30,599	966	2
3	21	CLERICAL & GENERAL	PATIENT DAYS	483,176	10	102,097		30,599	6,466	3
4	21	CLERICAL & GENERAL- SALA	PATIENT DAYS	483,176	10	557,621	557,621	30,599	35,314	4
5	24	BUSINESS SEMINAR	PATIENT DAYS	483,176	10	7,400		30,599	469	5
6	25	AUTO & TRAVEL	PATIENT DAYS	483,176	10	36,080		30,599	2,285	6
7	26	INSURANCE	PATIENT DAYS	483,176	10	2,507		30,599	159	7
8	27	EMPLOYEE BENEFITS/TAXES	PATIENT DAYS	483,176	10	110,789		30,599	7,016	8
9	34	RENT	PATIENT DAYS	483,176	10	21,600		30,599	1,368	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					\$ 856,240	\$ 557,621		\$ 54,225	25

Facility Name & ID Number Morton Terrace Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Healthcare And Rehabilitation Centre, LLC # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Healthcare And Rehabilitation Centre, Llc # 0052142 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							\$				\$	1
2												2
3												3
4												4
5					-							5
	Working Capital											
6	Allocated from 4600 Touhy	X									2,750	6
7												7
8					-							8
9	TOTAL Facility Related						\$				\$ 2,750	9
	B. Non-Facility Related*											
10	Interest Income		X								(2,702)	10
11												11
12												12
13					-							13
14	TOTAL Non-Facility Related						\$				\$ (2,702)	14
15	TOTALS (line 9+line14)						\$				\$ 48	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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

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

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
6													6
7	TOTAL Long-Term												7
	Working Capital												
8							\$					\$	8
9													9
10													10
11													11
12													12
13													13
14	TOTAL Working Capital												14
	B. Non-Facility Related*												
15							\$					\$	15
16													16
17													17
18													18
19													19
20	TOTAL Non-Facility Related												20

* 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.)

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAMEMorton Terrace Healthcare And Rehabilitation Centre, LlcCOUNTYTazewell

FACILITY IDPH LICENSE NUMBER0052142

CONTACT PERSON REGARDING THIS REPORTSteve Lavenda

TELEPHONE(847) 236-6300FAX #:(847) 236-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1. 06-06-29-115-003	Long Term Care Property	\$ 82,375.26	\$ 82,375.26
2. See Attached	Home Office Allocation	\$ 89,919.35	\$ 2,847.25
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 172,294.61	\$ 85,222.51

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Morton Terrace Healthcare And Rehabilitation Centre, Llc COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0052142

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.		\$	\$
2.		\$	\$
3.		\$	\$
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 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

36,948

B. General Construction Type:

Exterior

Frame

Number of Stories

C. Does the Operating Entity?

☐

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☒

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.					
	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		2013	\$ 469,511	1
2	Allocated from 4600 Touhy LLC			5,700	2
3	TOTALS			\$ 475,211	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	166		2013	1971	\$ 3,724,471	\$	39	\$ 95,499	\$ 95,499	\$ 381,996	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	Related Building Company (Pages 12F & 12G)							67
68	Related Party Allocations (Pages 12H & 12I)	66,394	1,506		2,777	1,271	13,555	68
69	Financial Statement Depreciation		44,220			(44,220)		69
70	TOTAL (lines 4 thru 69)	\$ 3,790,865	\$ 45,726		\$ 98,276	\$ 52,550	\$ 395,551	70

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

Facility Name & ID Number Morton Terrace Healthcare And Rehabilitation Centre, Llc

0052142

Report Period Beginning:

01/01/16

Ending:

12/31/16

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 12A, Carried Forward		\$ 3,790,865	\$ 45,726		\$ 98,276	\$ 52,550	\$ 395,551	1
2	Walk-In Cooler	2013	2,868		20	191	191	701	2
3	Water Heater	2013	4,950		20	495	495	1,774	3
4	A/C Unit - Rheem Rknl060	2013	6,482		20	1,296	1,296	4,537	4
5	A/C Unit - Rheem Condenser	2013	3,555		20	711	711	2,370	5
6	Installation Of Tankless Hot Water Heater	2013	4,950		20	248	248	887	6
7	Water Heater	2013	2,785		20	139	139	429	7
8	Air Compressor	2014	3,950		20	790	790	2,107	8
9	Landscaping & Fence Repairs	2014	5,500		20	275	275	688	9
10	Install New Condensor	2014	2,945		20	147	147	356	10
11	Installed 2 Furnaces	2014	13,905		20	695	695	1,854	11
12	C Wing Furnace Replacement	2014	3,150		20	158	158	354	12
13	Install 2 Furnaces & More Coil	2014	16,500		20	825	825	2,338	13
14	Keypad Door Alarm	2015	2,980		20	149	149	186	14
15	Heather Replacement	2015	3,100		20	155	155	168	15
16	Repair Leak In Laundry Room / Rebuild Supply Maulford - Wate	2015	2,880		20	144	144	228	16
17	Install New 4" Pipe For Fire System Leaking In Dining Room Are	2015	2,538		20	127	127	169	17
18	Repaired Leaking Pipe	2016	2,592		20	130	130	130	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)		\$ 3,876,495	\$ 45,726		\$ 104,951	\$ 59,225	\$ 414,827	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 12B, Carried Forward		\$ 3,876,495	\$ 45,726		\$ 104,951	\$ 59,225	\$ 414,827	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
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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)		\$ 3,876,495	\$ 45,726		\$ 104,951	\$ 59,225	\$ 414,827	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 12C, Carried Forward		\$ 3,876,495	\$ 45,726		\$ 104,951	\$ 59,225	\$ 414,827	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		\$ 3,876,495	\$ 45,726		\$ 104,951	\$ 59,225	\$ 414,827	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 12D, Carried Forward		\$ 3,876,495	\$ 45,726		\$ 104,951	\$ 59,225	\$ 414,827	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,876,495	\$ 45,726		\$ 104,951	\$ 59,225	\$ 414,827	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 Building Company		\$	\$		\$	\$	\$	1
2								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
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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	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from 4600 Touhy LLC	2012	32,517	834	30	1,084	250	5,419	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Mosaic Healthcare	2013	546		20	27	27	109	9
10	Allocated from Mosaic Healthcare	2012	6,789		20	339	339	1,697	10
11									11
12	Allocated from 4600 Touhy LLC	2012	20,941	539	20	1,047	508	5,235	12
13	Allocated from 4600 Touhy LLC	2013	5,095	120	20	255	135	1,019	13
14	Allocated from 4600 Touhy LLC	2014	506	13	20	25	12	76	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 66,394	\$ 1,506		\$ 2,777	\$ 1,271	\$ 13,555	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 12H, Carried Forward		\$ 66,394	\$ 1,506		\$ 2,777	\$ 1,271	\$ 13,555	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)		\$ 66,394	\$ 1,506		\$ 2,777	\$ 1,271	\$ 13,555	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	\$ 1,630,555	\$	\$ 172,820	\$ 172,820	10	\$ 450,878	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	16,264				10	16,264	73
74								74
75	TOTALS	\$ 1,646,819	\$	\$ 172,820	\$ 172,820		\$ 467,142	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 Mosaic HC	2016	\$ 6,016	\$	\$	\$	5	\$ 6,016	76
77										77
78										78
79										79
80	TOTALS			\$ 6,016	\$	\$	\$		\$ 6,016	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)	\$ 6,004,542	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 45,726	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 277,771	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 232,045	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 887,984	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:ARC Healthcare II Operating Partnership (Sale Leaseback Arrangement)
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

☒ YES

☐ NO
- If NO, see instructions.

		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:		166		\$ 296,010			3
4	Additions							4
5					(296,010)			5
6	Allocated from Platinum Billing Solutions				1,368			6
7	TOTAL		166		\$ 1,368			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized

by the length of the lease

9. Option to Buy:

☐ YES

☐ NO

Terms:

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES

☐ NO
16. Rental Amount for movable equipment: \$ 1,391Description: 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 Challenger	\$	16,073	17
18					18
19					19
20					20
21	TOTAL		\$ -	\$ 16,073	21

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2017	\$
13.	/2018	\$
14.	/2019	\$

* 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.

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.)

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 329,097	\$		\$ 329,097	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			37,995			37,995	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			208,240			208,240	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 prescrpts				85,453		85,453	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					192,175	14,261		206,436	13
14	TOTAL			\$		\$ 767,507	\$ 99,714		\$ 867,221	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.

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 107,331	\$	1
2	Cash-Patient Deposits	22,452		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,313,674		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	32,115		6
7	Other Prepaid Expenses	5,131		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	559,212		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,039,915	\$	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	65,258		15
16	Equipment, at Historical Cost	190,364		16
17	Accumulated Depreciation (book methods)	(129,614)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	543,405		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 669,413	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,709,328	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,840,419	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	22,452		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	86,387		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,159		31
32	Accrued Real Estate Taxes(Sch.IX-B)	73,175		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	126,190		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,154,782	\$	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	<u>See Attached Schedule</u>	2,462,170		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,462,170	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,616,952	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,907,624)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,709,328	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (878,185)	1
2	Restatements (describe):		2
3	PY Depreciation	(2,215)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (880,400)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,027,224)	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)	\$ (1,027,224)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,907,624)	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	\$ 6,629,878	1
2	Discounts and Allowances for all Levels	(1,248,322)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,381,556	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	869,666	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 869,666	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	71,594	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,886	19
20	Radiology and X-Ray	705	20
21	Other Medical Services	1,438	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 79,623	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,702	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,702	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	2,437	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,437	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,335,984	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,101,602	31
32	Health Care	2,722,570	32
33	General Administration	1,906,665	33
	B. Capital Expense		
34	Ownership	435,424	34
	C. Ancillary Expense		
35	Special Cost Centers	901,946	35
36	Provider Participation Fee	295,001	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,363,208	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,027,224)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,027,224)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,771,665	44
45	Private Pay - Net Inpatient Revenue	911,024	45
46	Medicare - Net Inpatient Revenue	523,975	46
47	Other-(specify) Hospice, Managed Care Medicare	1,159,417	47
48	Other-(specify) Insurance	15,475	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,381,556	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.

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	1,874	2,037	\$ 82,629	\$ 40.56	1
2	Assistant Director of Nursing	1,887	2,051	70,281	34.27	2
3	Registered Nurses	17,324	18,830	518,541	27.54	3
4	Licensed Practical Nurses	20,106	21,855	582,003	26.63	4
5	CNAs & Orderlies	68,760	74,740	936,932	12.54	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	155	169	3,623	21.44	8
9	Activity Director	1,663	1,808	26,537	14.68	9
10	Activity Assistants	9,914	10,776	127,471	11.83	10
11	Social Service Workers	3,359	3,651	72,423	19.84	11
12	Dietician					12
13	Food Service Supervisor	2,491	2,708	30,409	11.23	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,368	19,965	169,607	8.50	15
16	Dishwashers					16
17	Maintenance Workers	2,064	2,244	35,866	15.98	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,000	2,197	97,518	44.39	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,046	2,224	47,219	21.23	23
24	Clerical	8,448	9,183	130,948	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	2,389	2,597	51,042	19.65	31
32	Other Health Care(specify)					32
33	Other(specify)	1,689	1,837	24,252	13.20	33
34	TOTAL (lines 1 - 33)	164,537	178,872	\$ 3,007,301 *	\$ 16.81	34

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	\$ 9,935	01-03	35
36	Medical Director	Monthly	13,000	09-03	36
37	Medical Records Consultant	Monthly	2,040	10-03	37
38	Nurse Consultant	Monthly	29,880	10-03	38
39	Pharmacist Consultant	Monthly	7,375	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	75	11-03	44
45	Social Service Consultant	14	910	12-03	45
46	Other(specify) MDS Consultant	Monthly	29,880	10-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)	14	\$ 93,095		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number		Morton Terrace Healthcare And Rehabilitation Centri		STATE OF ILLINOIS		Report Period Beginning:		Page 21	
# 0052142						01/01/16		Ending: 12/31/16	
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	0.00%	\$ 54,741	Workers' Compensation Insurance	\$ 126,335	IDPH License Fee	\$		
Robin Lemasters	Administrator	0.00%	18,200	Unemployment Compensation Insurance	69,949	Advertising: Employee Recruitment		10,023	
Jerlene Jamison	Administrator	0.00%	24,577	FICA Taxes	221,460	Health Care Worker Background Check		1,802	
				Employee Health Insurance	29,042	(Indicate # of checks performed 163.8)			
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions		14,184	
				401K Match	1,418	License and Permits		4,351	
TOTAL (agree to Schedule V, line 17, col. 1)				Holiday Expense	350	Allocated from Mosaic HC		251	
(List each licensed administrator separately.)			\$ 97,518	Other Employee Benefits	3,628	Allocated from 4600 Touhy LLC		19	
B. Administrative - Other									
Description			Amount						
Management Fees - Tetrad Management			\$ 47,837						
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 47,837	TOTAL (agree to Schedule V, line 22, col.8)		\$ 452,182	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 30,630
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
C. Professional Services				Description	Line #	Amount	Description	Amount	
Vendor/Payee	Type		Amount						
Marcum LLP	Accounting		\$ 19,347			\$	Out-of-State Travel	\$	
Madison Specs	Cost Segregation		1,608						
Prospect Resources	Energy Procurement		36						
Ability Network	Data Processing		4,966				In-State Travel		
Creative Technology	Data Processing		2,747						
Provinet Solutions	Data Processing		1,391						
Sikich LLP	Data Processing		4,286						
Health MedX LLC	Data Processing		26,042				Seminar Expense		1,990
Galaxy Software	Data Processing		1,460				Allocated from Mosaic HC		119
SmartLinx	Data Processing		5,851				Allocated from Platinum Billing Solutions		469
Compu-Solutions	Data Processing		4,590						
See Supplemental Schedule			226,818				Entertainment Expense	(	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)		
(For legal fee disclosure, see page 39 of instructions)			\$ 299,142				TOTAL	\$	2,578
				* Attach copy of IMRF notifications			**See instructions.		

Facility Name & ID Number		Morton Terrace Healthcare And Rehabilitation Centre, Llc		STATE OF ILLINOIS	#	0052142	Report Period Beginning:	01/01/16	Ending:	12/31/16	Page 22
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?			Yes							
	If YES, give association name and amount.			IL Council on Long Term Care \$16,085							
(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 Years							
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.			\$ 28,668							
	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?			Yes							
	If YES, give effective date of lease.			12/31/2014							
(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.			\$ 295,001							
	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 benefit on Schedule V.			\$ N/A							
	Has any meal income been offset against related costs?			N/A							
(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?			Yes							
	See page 39 of the instructions for details.										
	Attach invoices and a summary of services for all architect and appraisal fees										