

Facility Name & ID Number CAPITOL CARE CENTER

0045666 Report Period Beginning: 1/01/06 Ending: 12/31/06

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	251	Skilled (SNF)	251	91,615	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	251	TOTALS	251	91,615	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	52,229	1,092	10,458	63,779	8
9	SNF/PED					9
10	ICF		4,728		4,728	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	52,229	5,820	10,458	68,507	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.78%

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

0 (Do not include bed-hold days in Section B.)

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

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

N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 10/01/01

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

YES Date 10/01/01 NO

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

YES NO If YES, enter number of beds certified 251 and days of care provided 10,458

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 1/01/06 Ending: 12/31/06

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 OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	287,611	44,641	14,767	347,019		347,019		347,019			1
2	Food Purchase		354,978		354,978		354,978	(132)	354,846			2
3	Housekeeping	129,123	36,574		165,697		165,697		165,697			3
4	Laundry	145,221	47,694		192,915		192,915		192,915			4
5	Heat and Other Utilities			224,192	224,192		224,192	7,673	231,865			5
6	Maintenance	140,982	158,551		299,533		299,533	8,010	307,543			6
7	Other (specify):*											7
8	TOTAL General Services	702,937	642,438	238,959	1,584,334		1,584,334	15,551	1,599,885			8
	B. Health Care and Programs											
9	Medical Director			28,640	28,640		28,640		28,640			9
10	Nursing and Medical Records	2,404,634	217,442	13,980	2,636,056		2,636,056		2,636,056			10
10a	Therapy	410,525		9,055	419,580		419,580		419,580			10a
11	Activities	61,952	16,740	3,629	82,321		82,321		82,321			11
12	Social Services	66,240		3,581	69,821		69,821		69,821			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,943,351	234,182	58,885	3,236,418		3,236,418		3,236,418			16
	C. General Administration											
17	Administrative	93,777		504,000	597,777		597,777	(451,683)	146,094			17
18	Directors Fees											18
19	Professional Services			86,923	86,923		86,923	3,105	90,028			19
20	Dues, Fees, Subscriptions & Promotions			69,592	69,592		69,592	(42,380)	27,212			20
21	Clerical & General Office Expenses	479,779	33,197	102,524	615,500		615,500	70,406	685,906			21
22	Employee Benefits & Payroll Taxes			812,772	812,772		812,772		812,772			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,767	9,767		9,767	166	9,933			24
25	Other Admin. Staff Transportation			47,345	47,345		47,345	2,127	49,472			25
26	Insurance-Prop.Liab.Malpractice			262,597	262,597		262,597	1,257	263,854			26
27	Other (specify):*							35,211	35,211			27
28	TOTAL General Administration	573,556	33,197	1,895,520	2,502,273		2,502,273	(381,791)	2,120,482			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,219,844	909,817	2,193,364	7,323,025		7,323,025	(366,240)	6,956,785			29

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

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

Facility Name & ID Number CAPITOL CARE CENTER

#0045666

Report Period Beginning:

1/01/06

Ending:

12/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			58,553	58,553	58,553	(173)	58,380				30
31	Amortization of Pre-Op. & Org.						370	370				31
32	Interest			49,041	49,041	49,041	8,804	57,845				32
33	Real Estate Taxes			101,683	101,683	101,683		101,683				33
34	Rent-Facility & Grounds			876,068	876,068	876,068		876,068				34
35	Rent-Equipment & Vehicles			173,448	173,448	173,448	1,151	174,599				35
36	Other (specify):*											36
37	TOTAL Ownership			1,258,793	1,258,793	1,258,793	10,152	1,268,945				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			377,214	377,214	377,214		377,214				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			136,670	136,670	136,670		136,670				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			513,884	513,884	513,884		513,884				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,219,844	909,817	3,966,041	9,095,702	9,095,702	(356,088)	8,739,614				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 CAPITOL CARE CENTER

0045666

Report Period Beginning: 1/01/06

Ending: 12/31/06

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	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(7,030)	30		9
10	Interest and Other Investment Income	(839)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(132)	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	(14,460)	21		18
19	Entertainment				19
20	Contributions	(9,605)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(40,376)	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	(10,920)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (83,362)		\$	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)	(272,726)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (272,726)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (356,088)		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	Exceptional Care Program					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

CAPITOL CARE CENTER

ID# 0045666

Report Period Beginning: 1/01/06

Ending: 12/31/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	BANK FEES	\$ (1,898)	21	1
2	TAXES-GENERAL	(983)	21	2
3	LOBBYING EXPENSE	(2,815)	20	3
4	REAL ESTATE TAXES	(5,224)	33	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				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	(10,920)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number **CAPITOL CARE CENTER**

0045666

Report Period Beginning:

1/01/06

Ending:

12/31/06

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(132)	0	0	0	0	0	0	0	0	0	0	(132)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	7,673	0	0	0	0	0	0	0	0	7,673	5
6	Maintenance	0	0	8,010	0	0	0	0	0	0	0	0	8,010	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(132)	0	15,683	0	15,551	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(451,683)	0	0	0	0	0	0	0	0	(451,683)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	3,105	0	0	0	0	0	0	0	0	3,105	19
20	Fees, Subscriptions & Promotions	(43,191)	0	811	0	0	0	0	0	0	0	0	(42,380)	20
21	Clerical & General Office Expenses	(26,946)	0	97,352	0	0	0	0	0	0	0	0	70,406	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	166	0	0	0	0	0	0	0	0	166	24
25	Other Admin. Staff Transportation	0	0	2,127	0	0	0	0	0	0	0	0	2,127	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,257	0	0	0	0	0	0	0	0	1,257	26
27	Other (specify):*	0	0	35,211	0	0	0	0	0	0	0	0	35,211	27
28	TOTAL General Administration	(70,137)	0	(311,654)	0	(381,791)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(70,269)	0	(295,971)	0	(366,240)	29							

STATE OF ILLINOIS

Facility Name & ID Number CAPITOL CARE CENTER

0045666

Report Period Beginning:

1/01/06

Ending:

Summary B

12/31/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(7,030)	0	6,857	0	0	0	0	0	0	0	0	(173)	30
31	Amortization of Pre-Op. & Org.	0	0	370	0	0	0	0	0	0	0	0	370	31
32	Interest	(839)	0	9,643	0	0	0	0	0	0	0	0	8,804	32
33	Real Estate Taxes	(5,224)	0	5,224	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	1,151	0	0	0	0	0	0	0	0	1,151	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(13,093)	0	23,245	0	10,152	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(83,362)	0	(272,726)	0	(356,088)	45							

Facility Name & ID Number CAPITOL CARE CENTER

0045666

Report Period Beginning:

1/01/06

Ending:

12/31/06

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	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.

Facility Name & ID Number CAPITOL CARE CENTER# 0045666

Report Period Beginning:

1/01/06

Ending:

12/31/06

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17 Home Office Expense	\$ 504,000	Platinum Healthcare, LLC	100.00%	\$	\$ (504,000)	15
16	V	5 Utilities		Platinum Healthcare, LLC	100.00%	7,673	7,673	16
17	V	6 Repairs & Maintenance		Platinum Healthcare, LLC	100.00%	8,010	8,010	17
18	V	17 Administrative Salary		Platinum Healthcare, LLC	100.00%	52,317	52,317	18
19	V	19 Professional Fees		Platinum Healthcare, LLC	100.00%	3,105	3,105	19
20	V	20 Fees, Subscriptions		Platinum Healthcare, LLC	100.00%	811	811	20
21	V	21 Clerical Salaries		Platinum Healthcare, LLC	100.00%	79,669	79,669	21
22	V	21 Office Expenses		Platinum Healthcare, LLC	100.00%	17,683	17,683	22
23	V	24 Education & Seminars		Platinum Healthcare, LLC	100.00%	166	166	23
24	V	25 Travel		Platinum Healthcare, LLC	100.00%	2,127	2,127	24
25	V	27 Employee Benefits		Platinum Healthcare, LLC	100.00%	35,211	35,211	25
26	V	26 Insurance		Platinum Healthcare, LLC	100.00%	1,257	1,257	26
27	V	30 Depreciation		Platinum Healthcare, LLC	100.00%	1,451	1,451	27
28	V	35 Equipment Rental		Platinum Healthcare, LLC	100.00%	1,151	1,151	28
29	V	31 Amortization		Platinum Healthcare, LLC	100.00%	370	370	29
30	V	30 Depreciation		Platinum Healthcare, LLC	100.00%	5,406	5,406	30
31	V	32 Interest		Platinum Healthcare, LLC	100.00%	9,643	9,643	31
32	V	33 Real Estate Taxes		Platinum Healthcare, LLC	100.00%	5,224	5,224	32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 504,000			\$ 231,274	\$ * (272,726)	39

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

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 1/01/06 Ending: 12/31/06

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Ben Klein	Owner	Administrative	33.33	See Attached	5	12.50	Mgt Fees	\$ 0	17-03	1
2	Brian Levinson	Owner	Administrative	33.33	See Attached	8	20.00	Mgt Fees	0	17-03	2
3	Mark Shapiro	Owner	Administrative	33.33	See Attached	8	20.00	Mgt Fees	0	17-03	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 0		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 CAPITOL CARE CENTER

0045666

Report Period Beginning:

1/01/06

Ending: 12/31/06

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 Platinum Healthcare, LLC
 Street Address 7444 Long Ave.
 City / State / Zip Code Skokie, IL 60077
 Phone Number (847) 329-4100
 Fax Number (847) 329-7652

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	Patient Days	369,267	8	\$ 41,358	\$ 68,507	\$ 7,673	1	
2	6	Repairs & Maintenance	Patient Days	369,267	8	43,174	68,507	8,010	2	
3	17	Administrative Salary	Patient Days	369,267	8	282,000	282,000	68,507	52,317	3
4	19	Professional Fees	Patient Days	369,267	8	16,736	68,507	3,105	4	
5	20	Fees, Subscriptions	Patient Days	369,267	8	4,372	68,507	811	5	
6	21	Clerical Salaries	Patient Days	369,267	8	429,429	429,429	68,507	79,668	6
7	21	Office Expenses	Patient Days	369,267	8	95,317	68,507	17,683	7	
8	24	Education & Seminars	Patient Days	369,267	8	895	68,507	166	8	
9	25	Travel	Patient Days	369,267	8	11,467	68,507	2,127	9	
10	27	Employee Benefits	Patient Days	369,267	8	189,793	68,507	35,211	10	
11	26	Insurance	Patient Days	369,267	8	6,774	68,507	1,257	11	
12	30	Depreciation	Patient Days	369,267	8	7,823	68,507	1,451	12	
13	35	Equipment Rental	Patient Days	369,267	8	6,203	68,507	1,151	13	
14	31	Amortization	Patient Days	369,267	8	1,993	68,507	370	14	
15	30	Depreciation	Patient Days	369,267	8	29,142	68,507	5,406	15	
16	32	Interest	Patient Days	369,267	8	51,980	68,507	9,643	16	
17	33	Real Estate Taxes	Patient Days	369,267	8	28,158	68,507	5,224	17	
18	21	rounding						1	18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,246,614	\$ 711,429	\$ 231,274	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	Allocation from Platinum								9,643	3										
4										4										
5										5										
Working Capital																				
6	Albany Bank & Trust		X	Line of Credit		1,000,000			49,041	6										
7										7										
8										8										
9	TOTAL Facility Related					\$ 1,000,000			\$ 58,684	9										
B. Non-Facility Related*																				
10	Interest Income								(839)	10										
11										11										
12										12										
13										13										
14	TOTAL Non-Facility Related					\$			\$ (839)	14										
15	TOTALS (line 9+line14)					\$ 1,000,000			\$ 57,845	15										

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.)

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 2005 report.		\$	96,000	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.)		\$	101,683	2
3. Under or (over) accrual (line 2 minus line 1).		\$	5,683	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	96,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	101,683	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2001	92,074	8	
	2002	65,954	9	
	2003	93,952	10	
	2004	98,617	11	
	2005	101,683	12	

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2005	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CAPITOL CARE CENTER COUNTY SANGAMON

FACILITY IDPH LICENSE NUMBER 0045666

CONTACT PERSON REGARDING THIS REPORT DARRYL BUEKER

TELEPHONE (417) 865-8701 FAX #: (417) 865-0682

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(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>14-28.0-401-018</u>	<u>Long Term Care Property</u>	\$ <u>98,352.44</u>	\$ <u>98,352.44</u>
2. <u>14-28.0-401-006</u>	<u>Long Term Care Property</u>	\$ <u>3,330.12</u>	\$ <u>3,330.12</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>101,682.56</u>	\$ <u>101,682.56</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number CAPITOL CARE CENTER

0045666 Report Period Beginning:

1/01/06 Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 61,806 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 4

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number **CAPITOL CARE CENTER**# **0045666**

Report Period Beginning:

1/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		AWNING		2001	6,950		20	348	348	1,798	9
10		SIGNS & BANNERS		2001	4,354		10	435	435	2,211	10
11		A/C		2002	505		5	101	101	440	11
12		A/C		2002	5,263		7	752	752	3,635	12
13		MASONRY RESTORATION		2002	4,098		10	410	410	1,845	13
14		CEILING WORK		2002	1,500		20	75	75	375	14
15		CEILING WORK		2002	1,835		20	92	92	444	15
16		DOORS		2002	5,665		10	567	567	2,457	16
17		INSTALL GLASS		2002	735		10	74	74	370	17
18		A/C REPAIR		2002	1,202		10	120	120	555	18
19		ELEVATOR REPAIR		2002	2,320		20	116	116	551	19
20		INSTALL GLASS		2002	550		10	55	55	257	20
21		A/C REPAIR		2002	899		10	90	90	397	21
22		FIRE SPRINKLER REPAIR		2002	1,383		10	138	138	610	22
23		WATER PUMP REPAIR		2002	1,566		10	157	157	654	23
24		WATER HEATER		2002	10,018		12	835	835	3,966	24
25		THERMOSTAT REPAIR		2002	2,287		10	229	229	1,107	25
26		THERMOSTAT REPAIR		2002	825		10	83	83	353	26
27		REPAIR KITCHEN EQUIP		2002	1,695		10	170	170	850	27
28		INSTALL SIGNS		2002	2,710		10	271	271	1,355	28
29		INSTALL SIGNS		2002	718		10	72	72	360	29
30		ACCESS CONTROL SYSTEM		2002	3,482		10	348	348	1,740	30
31		ACCESS CONTROL SYSTEM		2002	2,646		10	265	265	1,325	31
32		ACCESS CONTROL SYSTEM		2002	588		10	59	59	290	32
33		INSTALL SIGNS		2002	977		10	98	98	473	33
34		SHOWER & GUARD RAILS		2002	535		20	27	27	115	34
35		CALL CORDS		2002	599		20	30	30	140	35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number **CAPITOL CARE CENTER**# **0045666**

Report Period Beginning:

1/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	RAIL POST	2002	\$ 540	\$	20	\$ 27	\$ 27	\$ 119	37
38	CURTAIN FOR MAIN DINING ROOM	2003	849		5	170	170	609	38
39	REPLACEMENT FOR ZONAIRE	2003	5,565		20	278	278	904	39
40	FURNISH & INSTALL NEW CONDENSER	2003	1,521		20	76	76	241	40
41	A/C UNIT	2003	1,100		5	220	220	697	41
42	HOYER LIFT	2003	19,216		10	1,922	1,922	5,926	42
43	NURSES STATION REMODEL	2004	7,877		15	525	525	1,269	43
44	ALTERNATE FLOOR FIRE SVCS	2004	3,255		10	326	326	896	44
45	OVERHAUL 2 ELEVATORS	2004	40,080		20	2,004	2,004	5,177	45
46	CARPET	2004	9,720		5	1,944	1,944	4,374	46
47	CONSTRUCT NEW OFFICE SPACE	2005	8,000		27.5	291	291	388	47
48	ZONE RESTRICTOR SYSTEM	2005	5,950		27.5	216	216	306	48
49	CARPET	2005	5,754		5	1,151	1,151	1,343	49
50	FIRE SPRINKLERS	2006	7,867		25	236	236	236	50
51	REPAIRED DRAIN	2006	2,758		20	103	103	103	51
52	10-A/C FAN BLADES	2006	1,001		10	67	67	67	52
53	SOLAR CONTROL WINDOW	2006	1,442		10	60	60	60	53
54	DRIER & CONDENSER	2006	2,093		10	70	70	70	54
55	DRAIN PIPE & SHOWER VALVE	2006	2,277		20	38	38	38	55
56	DOORS	2006	6,806		20				56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66	Allocation from Platinum Health Care (Bldg & Improv)			2,403		2,403			66
67									67
68									68
69				8,614			(8,614)		69
70	TOTAL (lines 4 thru 69)		\$ 199,576	\$ 11,017		\$ 18,144	\$ 7,127	\$ 51,496	70

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

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 1/01/06 Ending: 12/31/06

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 244,352	\$ 34,302	\$ 31,237	\$ (3,065)		\$ 115,771	71
72	Current Year Purchases	106,534	15,637	4,545	(11,092)		4,545	72
73	Fully Depreciated Assets							73
74	Allocation from Platinum HC	44,546	6,881	4,454	(2,427)			74
75	TOTALS	\$ 395,432	\$ 56,820	\$ 40,236	\$ (16,584)		\$ 120,316	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 595,008	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 67,837	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 58,380	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (9,457)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 171,812	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 CAPITOL CARE CENTER

0045666

Report Period Beginning:

1/01/06

Ending: 12/31/06

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ <u>876,068</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ <u>876,068</u>			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.	<u>/2007</u>	\$ _____
13.	<u>/2008</u>	\$ _____
14.	<u>/2009</u>	\$ _____

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: \$ 142,826 Description: See attached list

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>See attached list</u>		\$ _____	\$ <u>31,773</u>	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ <u>31,773</u>	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 CAPITOL CARE CENTER # 0045666 Report Period Beginning: 1/01/06 Ending: 12/31/06

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)			
			Units of Service	Cost	Units	Cost						
											2	3
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1		
2	Licensed Speech and Language Development Therapist		hrs							2		
3	Licensed Recreational Therapist		hrs							3		
4	Licensed Physical Therapist	10a-03	hrs			9,055			9,055	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				359,507		359,507	9		
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10		
11	Academic Education		hrs							11		
12	Exceptional Care Program									12		
13	Other (specify): Lab & X-ray	39-02					17,707		17,707	13		
14	TOTAL			\$		\$	9,055	\$	377,214	\$	386,269	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 CAPITOL CARE CENTER # 0045666 Report Period Beginning: 1/01/06 Ending: 12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/06 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ (91,206)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>380,201</u>)	3,027,930		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	345,497		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,282,221	\$	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	187,780		15
16	Equipment, at Historical Cost	361,008		16
17	Accumulated Depreciation (book methods)	(285,064)		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):	529,381		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 793,105	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,075,326	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,435,467	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	229,323		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	96,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accrued Expenses</u>	427,335		36
37	<u>Due Others & Advance Billing</u>	557		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,188,682	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	1,000,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,000,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,188,682	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 886,644	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,075,326	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 509,596	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 509,596	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(122,952)	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) Capital Contributions	500,000	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 377,048	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)	\$ 886,644	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number CAPITOL CARE CENTER# 0045666Report Period Beginning: 1/01/06Ending: 12/31/06**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,031,564	1
2	Discounts and Allowances for all Levels	(287,274)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,744,290	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,477,012	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,477,012	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	727,275	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	18,786	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 746,061	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	839	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 839	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending \$4,284; Misc. \$264	4,548	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,548	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,972,750	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,584,334	31
32	Health Care	3,236,418	32
33	General Administration	2,502,273	33
B. Capital Expense			
34	Ownership	1,258,793	34
C. Ancillary Expense			
35	Special Cost Centers	377,214	35
36	Provider Participation Fee	136,670	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,095,702	40
41	Income before Income Taxes (line 30 minus line 40)**	(122,952)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (122,952)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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 **CAPITOL CARE CENTER**

0045666

Report Period Beginning:

1/01/06

Ending:

12/31/06

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	1,845	2,180	\$ 84,040	\$ 38.55	1
2	Assistant Director of Nursing	9,087	10,025	213,284	21.28	2
3	Registered Nurses	4,486	4,668	104,791	22.45	3
4	Licensed Practical Nurses	43,981	46,066	796,179	17.28	4
5	CNAs & Orderlies	111,507	114,797	1,206,340	10.51	5
6	CNA Trainees					6
7	Licensed Therapist	5,698	5,990	242,753	40.53	7
8	Rehab/Therapy Aides	7,449	8,081	167,772	20.76	8
9	Activity Director	1,517	1,980	23,964	12.10	9
10	Activity Assistants	4,005	4,301	37,988	8.83	10
11	Social Service Workers	4,279	4,718	66,240	14.04	11
12	Dietician					12
13	Food Service Supervisor	795	825	15,115	18.32	13
14	Head Cook					14
15	Cook Helpers/Assistants	31,483	32,975	272,496	8.26	15
16	Dishwashers					16
17	Maintenance Workers	11,322	12,051	140,982	11.70	17
18	Housekeepers	15,138	15,866	129,123	8.14	18
19	Laundry	13,677	14,678	145,221	9.89	19
20	Administrator	1,868	1,988	93,777	47.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	21,701	22,696	479,779	21.14	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	289,838	303,885	\$ 4,219,844 *	\$ 13.89	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	295	\$ 14,767	01-03	35
36	Medical Director	Monthly	28,640	09-03	36
37	Medical Records Consultant	Monthly	1,500	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	12,480	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	62	3,582	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	357	\$ 60,969		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

