

Facility Name & ID Number Central Nursing

0019364 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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 245

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>245</u>	Skilled (SNF)	<u>245</u>	<u>89,425</u>	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	<u>245</u>	TOTALS	<u>245</u>	<u>89,425</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>78,981</u>	<u>883</u>	<u>6,269</u>	<u>86,133</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>78,981</u>	<u>883</u>	<u>6,269</u>	<u>86,133</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.32%

D. How many bed-hold days during this year were paid by the Department? 2,302 (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 01/01/1973

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 22 and days of care provided 4,532

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	166,380	32,688	16,414	215,482		215,482	45,000	260,482		1
2	Food Purchase		185,308		185,308	(12,228)	173,080	(6,529)	166,551		2
3	Housekeeping	186,530	9,580		196,110		196,110		196,110		3
4	Laundry		7,712		7,712		7,712		7,712		4
5	Heat and Other Utilities			143,487	143,487		143,487	3,464	146,951		5
6	Maintenance	22,224	34,148	5,799	62,171		62,171	35,417	97,588		6
7	Other (specify):*			8,801	8,801		8,801		8,801		7
8	TOTAL General Services	375,134	269,436	174,501	819,071	(12,228)	806,843	77,352	884,195		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,716,882	76,028	28,027	1,820,937		1,820,937		1,820,937		10
10a	Therapy			26,415	26,415		26,415		26,415		10a
11	Activities	57,425	440		57,865		57,865		57,865		11
12	Social Services			3,236	3,236		3,236		3,236		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,774,307	76,468	57,678	1,908,453		1,908,453		1,908,453		16
	C. General Administration										
17	Administrative			488,592	488,592		488,592	(261,020)	227,572		17
18	Directors Fees										18
19	Professional Services			78,961	78,961		78,961		78,961		19
20	Dues, Fees, Subscriptions & Promotions			61,000	61,000		61,000	(28,954)	32,046		20
21	Clerical & General Office Expenses	261,098	6,989	9,971	278,058		278,058	135,451	413,509		21
22	Employee Benefits & Payroll Taxes			852,272	852,272	12,228	864,500	39,143	903,643		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,415	1,415		1,415		1,415		24
25	Other Admin. Staff Transportation			1,899	1,899		1,899	779	2,678		25
26	Insurance-Prop.Liab.Malpractice			179,255	179,255		179,255		179,255		26
27	Other (specify):* Bad debts			173,390	173,390		173,390	(172,593)	797		27
28	TOTAL General Administration	261,098	6,989	1,846,755	2,114,842	12,228	2,127,070	(287,194)	1,839,876		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,410,539	352,893	2,078,934	4,842,366		4,842,366	(209,842)	4,632,524		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

Central Nursing

#0019364

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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			16,837	16,837		16,837	35,745	52,582			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes					246,387	246,387		246,387			33
34	Rent-Facility & Grounds			1,453,624	1,453,624	(246,387)	1,207,237	(1,206,807)	430			34
35	Rent-Equipment & Vehicles			2,278	2,278		2,278	717	2,995			35
36	Other (specify):*											36
37	TOTAL Ownership			1,472,739	1,472,739		1,472,739	(1,170,345)	302,394			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		282,848	275	283,123		283,123		283,123			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			134,138	134,138		134,138		134,138			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		282,848	134,413	417,261		417,261		417,261			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,410,539	635,741	3,686,086	6,732,366		6,732,366	(1,380,187)	5,352,179			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	35,745	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(6,529)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(276)	21		18
19	Entertainment				19
20	Contributions	(400)	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	(173,390)	27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(25,542)	20		28
29	Other-Attach Schedule	(2,987)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (173,379)		\$	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	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)	(1,206,808)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,206,808)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,380,187)		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

Central Nursing

ID# 0019364

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non Deductible Dues	\$ (4,061)	20	1
2	Franchise Tax	(100)	21	2
3	Gasoline (Schedule Attached)	674	25	3
4	Background Checks (Schedule Attached)	500	20	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	(2,987)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Central Nursing# 0019364

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	45,000	0	0	0	0	0	0	0	0	45,000	1
2	Food Purchase	(6,529)	0	0	0	0	0	0	0	0	0	0	(6,529)	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	3,464	0	0	0	0	0	0	0	0	0	3,464	5
6	Maintenance	0	1,585	33,832	0	0	0	0	0	0	0	0	35,417	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(6,529)	5,049	78,832	0	77,352	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	(488,592)	227,572	0	0	0	0	0	0	0	0	(261,020)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(29,103)	149	0	0	0	0	0	0	0	0	0	(28,954)	20
21	Clerical & General Office Expenses	(776)	914	135,313	0	0	0	0	0	0	0	0	135,451	21
22	Employee Benefits & Payroll Taxes	0	39,143	0	0	0	0	0	0	0	0	0	39,143	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	674	0	105	0	0	0	0	0	0	0	0	779	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(173,390)	797	0	0	0	0	0	0	0	0	0	(172,593)	27
28	TOTAL General Administration	(202,595)	(447,589)	362,990	0	(287,194)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(209,124)	(442,540)	441,822	0	(209,842)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Central Nursing# 0019364

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	35,745	0	0	0	0	0	0	0	0	0	0	35,745	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,206,807)	0	0	0	0	0	0	0	0	0	(1,206,807)	34
35	Rent-Equipment & Vehicles	0	717	0	0	0	0	0	0	0	0	0	717	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	35,745	(1,206,090)	0	0	0	0	0	0	0	0	0	(1,170,345)	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)	(173,379)	(1,648,630)	441,822	0	(1,380,187)	45							

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
Marvin Mermelstein	50.00%	Winston Manor Nursing Home	Chicago	Nivram Mngt, Inc.	Lincolnwood, IL	Managemet
Joseph Mermelstein	50.00%	Balmoral Home, Inc.	Chicago			
		Chicago Ridge Nursing Center	Chicago Ridge			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 Management fees	\$ 488,592	Nivram Management, Inc.	50.00%	\$	(488,592)	1
2	V	21 Bank Charges		Nivram Management, Inc.	50.00%	23	23	2
3	V	21 Office Expenses		Nivram Management, Inc.	50.00%	891	891	3
4	V	20 Dues & Subscriptions		Nivram Management, Inc.	50.00%	149	149	4
5	V	27 Franchise Tax		Nivram Management, Inc.	50.00%	28	28	5
6	V	22 Payroll Taxes		Nivram Management, Inc.	50.00%	36,394	36,394	6
7	V	5 Utilities		Nivram Management, Inc.	50.00%	3,464	3,464	7
8	V	27 Insurance		Nivram Management, Inc.	50.00%	769	769	8
9	V	6 Repairs & Maintenance		Nivram Management, Inc.	50.00%	1,303	1,303	9
10	V	22 Health Insurance		Nivram Management, Inc.	50.00%	2,749	2,749	10
11	V	6 Scavenger		Nivram Management, Inc.	50.00%	282	282	11
12	V	34 Rent	1,206,807	Henry Mermelstein	50.00%		(1,206,807)	12
13	V	35 Equipment Rental		Nivram Management, Inc.	50.00%	717	717	13
14	Total		\$ 1,695,399			\$	\$ * (1,648,630)	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	25 Auto Expense	\$	Nivram Management, Inc.	50.00%	\$ 105	\$	105	15
16	V	21 Postage		Nivram Management, Inc.	50.00%	730		730	16
17	V	21 Data Processing		Nivram Management, Inc.	50.00%	456		456	17
18	V	21 Telephone		Nivram Management, Inc.	50.00%	1,423		1,423	18
19	V	6 Plant Salary		Nivram Management, Inc.	50.00%	33,832		33,832	19
20	V	17 Asst. Administrator		Nivram Management, Inc.	50.00%	50,748		50,748	20
21	V	21 Office Manager		Nivram Management, Inc.	50.00%	20,824		20,824	21
22	V	1 Dietary Supervisor		Nivram Management, Inc.	50.00%	45,000		45,000	22
23	V	17 Administrator		Nivram Management, Inc.	50.00%	150,040		150,040	23
24	V	17 Administrator		Nivram Management, Inc.	50.00%	26,784		26,784	24
25	V	21 Administrator		Nivram Management, Inc.	50.00%	2,897		2,897	25
26	V	21 Clerical		Nivram Management, Inc.	50.00%	108,983		108,983	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		\$			\$ 441,822	\$ *	441,822	39

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

Facility Name & ID Number

Central Nursing

0019364

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	Henry Mermelstein	Administrator	Administrative	None	124,960	22	54.56	Salary	\$ 150,040	L 17, Col 8	1
2	Louise Mermelstein	Dietary Supervisor	Support	None	45,000	20	50.00	Salary	45,000	L 1, Col 8	2
3	Marvin Mermelstein	Plant Supervisor	Support	50.00	86,168	5	28.19	Salary	33,832	L 6, Col 8	3
4	Doreen Mermelstein	Office Manager	Administrative	None	82,736	8	20.11	Salary	20,824	L 21, Col 8	4
5											5
6	Marvin Mermelstein	Asst. Administrator	Administrative	See Above	129,252	8	28.19	Salary	50,748	L 17, Col 8	6
7	Joseph Mermelstein	Owner	Administrative	50.00	68,216	3	28.19	Salary	26,784	L 17, Col 8	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 327,228		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 Central Nursing

0019364

Report Period Beginning:

01/01/2006

Ending: 2/31/2006

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 Nivram Management, Inc.
 Street Address 6500 N. Hamlin Avenue
 City / State / Zip Code Lincolnwood, IL 60712
 Phone Number (847) 679-7484
 Fax Number (847) 679-7494

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

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	Bank Charges	Resident Beds	869	4	\$ 80	\$	245	\$ 23	1
2	Office Expenses	Resident Beds	869	4	3,160		245	891	2
3	Dues & Subscriptions	Resident Beds	869	4	530		245	149	3
4	Franchise Tax	Resident Beds	869	4	100		245	28	4
5	Payroll Taxes	Resident Beds	869	4	129,086		245	36,394	5
6	Utilities	Resident Beds	869	4	12,288		245	3,464	6
7	Insurance	Resident Beds	869	4	2,728		245	769	7
8	Repairs & Maintenance	Resident Beds	869	4	4,620		245	1,303	8
9	Health Insurance	Resident Beds	869	4	9,750		245	2,749	9
10	Scavenger	Resident Beds	869	4	1,000		245	282	10
11	Equipment Rental	Resident Beds	869	4	2,544		245	717	11
12	Auto Expense	Resident Beds	869	4	374		245	105	12
13	Postage	Resident Beds	869	4	2,591		245	730	13
14	Data Processing	Resident Beds	869	4	1,616		245	456	14
15	Telephone	Resident Beds	869	4	5,049		245	1,423	15
16	Plant Salary	Direct Cost	1	1	33,832	33,832	1	33,832	16
17	Asst. Administrator	Direct Cost	1	1	50,748	50,748	1	50,748	17
18	Office Manager	Direct Cost	1	1	20,824	20,824	1	20,824	18
19	Dietary Supervisor	Direct Cost	1	1	45,000	45,000	1	45,000	19
20	Administrative	Direct Cost	1	1	179,721	179,721	1	179,721	20
21	Clerical	Direct Cost	1	1	108,983	108,983	1	108,983	21
22									22
23									23
24									24
25	TOTALS				\$ 614,624	\$ 439,108		\$ 488,591	25

Facility Name & ID Number Central Nursing

0019364

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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		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											6							
7											7							
8											8							
9	TOTAL Facility Related					\$	\$			\$	9							
B. Non-Facility Related*																		
10											10							
11											11							
12											12							
13											13							
14	TOTAL Non-Facility Related					\$	\$			\$	14							
15	TOTALS (line 9+line14)					\$	\$			\$	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ 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.		\$	209,600	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.)		\$	246,387	2
3. Under or (over) accrual (line 2 minus line 1).		\$	36,787	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	209,600	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.		\$	246,387	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2001	203,521	8	
	2002	205,803	9	
	2003	238,603	10	
	2004	243,903	11	
	2005	246,387	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 Central Nursing COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0019364

CONTACT PERSON REGARDING THIS REPORT Sandford B. Alper

TELEPHONE (847) 580-4100 FAX #: (847) 580-4199

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>13-29-431-013-0000</u>	<u>2450 N. Central Avenue</u>	<u>\$ 13,692.66</u>	<u>\$ 13,692.66</u>
2. <u>13-29-431-014-0000</u>	<u>2451 N. Central Avenue</u>	<u>\$ 33,837.21</u>	<u>\$ 33,837.21</u>
3. <u>13-29-431-015-0000</u>	<u>2452 N. Central Avenue</u>	<u>\$ 33,888.70</u>	<u>\$ 33,888.70</u>
4. <u>13-29-431-016-0000</u>	<u>2453 N. Central Avenue</u>	<u>\$ 33,888.70</u>	<u>\$ 33,888.70</u>
5. <u>13-29-431-017-0001</u>	<u>2454 N. Central Avenue</u>	<u>\$ 33,847.85</u>	<u>\$ 33,847.85</u>
6. <u>13-29-431-018-0002</u>	<u>2455 N. Central Avenue</u>	<u>\$ 33,766.99</u>	<u>\$ 33,766.99</u>
7. <u>13-29-431-019-0003</u>	<u>2456 N. Central Avenue</u>	<u>\$ 33,649.82</u>	<u>\$ 33,649.82</u>
8. <u>13-29-431-020-0004</u>	<u>2457 N. Central Avenue</u>	<u>\$ 26,828.61</u>	<u>\$ 26,828.61</u>
9. <u>13-29-431-021-0005</u>	<u>2458 N. Central Avenue</u>	<u>\$ 1,450.21</u>	<u>\$ 1,450.21</u>
10. <u>13-29-431-022-0006</u>	<u>2459 N. Central Avenue</u>	<u>\$ 1,535.98</u>	<u>\$ 1,535.98</u>
	TOTALS	\$ 246,386.73	\$ 246,386.73

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 Central Nursing

0019364 Report Period Beginning:

01/01/2006 Ending:

12/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 67,185 B. General Construction Type: Exterior Brick Frame Steel 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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>	<u>30,000</u>	<u>1973</u>	<u>\$ 158,977</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	30,000		\$ 158,977	3

Facility Name & ID Number Central Nursing

0019364

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	245	1973	1973	\$ 1,729,156	\$	30	\$	\$	\$ 1,729,156	4
5				(95,563)						5
6										6
7										7
8										8
	Improvement Type**									
9	Sprinkler System		1976	8,246		20			8,246	9
10	Hot Water Heater		1983	2,156		10			2,156	10
11	Light Fixtures		1984	14,684		10			14,684	11
12	Roof		1984	20,000		20			20,000	12
13	Heating & Air Conditioning		1983	2,924		20			2,924	13
14	Painting & Decorating		1983	7,863		8			7,863	14
15	Doorways		1986	1,840		15			1,840	15
16	Elevator Upgrade		1986	1,080	57	20	54	(3)	1,080	16
17	Wall Corner Guard		1987	1,531	49	10		(49)	1,531	17
18	Resurface Parking Lot		1987	6,900	106	15		(106)	6,794	18
19	Additions		1988	1,200	39	20	60	21	1,003	19
20	Heater Foundation		1989	1,000	32	20	50	18	785	20
21	Roof		1990	7,916	252	20	396	144	5,987	21
22	Roof		1990	2,199	70	8		(70)	2,199	22
23	Various Improvements		1990	1,850		8			1,850	23
24	Cubicle Curtains		1992	11,273	358	10		(358)	11,273	24
25	HVAC Improvements		1993	8,907		10			8,907	25
26	Draperies		1993	2,700		10			2,700	26
27	Tiling		1995	6,600	169	10		(169)	6,228	27
28	Leasehold Improvements		1995	15,914		10			15,380	28
29	Generator		1996	17,527	449	10	1,753	1,304	14,787	29
30	Roof		1996	4,800	123	10	480	357	4,049	30
31	Doorways		1997	2,465	63	10	247	184	1,836	31
32	Wiring for Emergency System		1997	5,000	128	10	500	372	3,718	32
33	Phone System		1997	8,238		10	824	824	5,751	33
34	Architecture		1998	6,000	154	10	600	446	3,861	34
35	Boiler, A/C, Ductwork		1998	16,664	427	10	1,666	1,239	10,652	35
36										36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number Central Nursing

0019364

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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	Roofing	1998	\$ 54,000	\$ 1,385	10	\$ 5,400	\$ 4,015	\$ 34,755	37
38	Parking Lot Improvement	1998	8,000		10	800	800	5,333	38
39	Elevator Improvements	1998	4,450	136	10	445	309	2,349	39
40	HVAC Improvements	1998	2,820	73	10	282	209	1,533	40
41	Fire Alarm System Doors	1999	107,500	2,756	10	10,750	7,994	58,435	41
42	Extended Walls Through Ceiling	1999	3,000	77	10	300	223	1,631	42
43	Elevator Improvements	1999	2,650	68	10	265	197	1,445	43
44	HVAC Improvements	1999	20,388	523	10	2,039	1,516	11,078	44
45	Landscape Work	1999	4,100	105	10	410	305	2,228	45
46	Elevator Improvements	2000	89,750	2,301	10	8,975	6,674	39,812	46
47	HVAC Improvements	2000	23,639	606	10	2,364	1,758	10,486	47
48	Telephone System	2000	7,500	193	10	750	557	3,327	48
49	Air Conditioning System	2001	4,000	102	10	400	298	1,510	49
50	Air Conditioning System	2001	10,800	277	10	1,080	803	3,126	50
51	Air Conditioning System	2001	2,500	45	10	250	205	550	51
52	Air Conditioning System	2003	5,800	74	10	580	506	3,150	52
53	Door	2004	1,742	45	10	174	129	93	53
54	Nurse Call System	2005	11,000	282	10	1,100	818	517	54
55	Dual Patient Stations	2005	1,485	38	10	149	111	70	55
56	Wiring-Elevator Recall Relays	2005	480	12	10	48	36	14	56
57	Air Cleaning Equipment	2005	2,936	75	10	294	219	113	57
58	Condenser	2005	1,780	45	10	178	133	68	58
59	Fan Coil Unit	2005	2,832	73	10	283	210	85	59
60	Hot Water Heater	2006	3,100	121	10	310	189	121	60
61	Water Heater	2006	6,000	33	10	600	567	33	61
62	A/C Compressor	2006	8,190	228	10	819	591	228	62
63	Emergency Light Connected to Fire Alarm	2006	595	10	10	59	49	10	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,212,107	\$ 12,159		\$ 45,734	\$ 33,575	\$ 2,079,340	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 57,034	\$ 4,440	\$ 5,703	\$ 1,263		\$ 50,668	71
72	Current Year Purchases	3,872	238	387	149		238	72
73	Fully Depreciated Assets	352,570					352,570	73
74	Nivram Management Depr			758	758			74
75	TOTALS	\$ 413,476	\$ 4,678	\$ 6,848	\$ 2,170		\$ 403,476	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	Facility Storage	Storage Trailer	1986	\$ 900	\$	\$	\$	10	\$ 900	76
77	Administrative	1999 Oldsmobile	1999	22,218				6	22,218	77
78										78
79										79
80	TOTALS			\$ 23,118	\$	\$	\$		\$ 23,118	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)	\$ 2,807,678	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 16,837	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 52,582	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 35,745	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,505,934	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ _____			7

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

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 2,278 Description: Ice Makers \$900; Copy Machine \$1,378

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	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. _____/2007 \$ _____

13. _____/2008 \$ _____

14. _____/2009 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$				1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care	39-3	6 visits	275				6	275	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				249,369		249,369	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>Rentals</u>	39-2					33,479		33,479	13
14	TOTAL			\$ 275		\$	\$ 282,848	6	\$ 283,123	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 Central Nursing

0019364

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,358,987	\$ 1,358,987	1
2	Cash-Patient Deposits	50,172	50,172	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	773,627	773,627	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	89,428	89,428	6
7	Other Prepaid Expenses	2,482	2,482	7
8	Accounts Receivable (owners or related parties)	2,532,552	2,532,552	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,807,248	\$ 4,807,248	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		158,977	13
14	Buildings, at Historical Cost		1,729,156	14
15	Leasehold Improvements, at Historical Cost	492,733	533,978	15
16	Equipment, at Historical Cost	293,071	530,429	16
17	Accumulated Depreciation (book methods)	(403,114)	(2,269,132)	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>Deposits</u>	500,100	500,100	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 882,790	\$ 1,183,508	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,690,038	\$ 5,990,756	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 581,604	\$ 581,604	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	50,900	50,900	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	143,827	143,827	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	209,600	209,600	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	40,793	40,793	35
	Other Current Liabilities(specify):			
36	<u>Accrued Rent</u>	1,104,069	1,104,069	36
37	<u>Due to IDPA</u>	79,394	79,394	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,210,187	\$ 2,210,187	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,210,187	\$ 2,210,187	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,479,851	\$ 3,780,569	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,690,038	\$ 5,990,756	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,224,381	1
2	Restatements (describe):		2
3	Prior Year Pharmacy Purchases	(250,000)	3
4	Prior Year Decrease in State Income Tax	3,595	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,977,976	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,916,875	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	(2,415,000)	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)	\$ 501,875	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)	\$ 3,479,851	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

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 9,477,725	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,477,725	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	11,369	6
7	Oxygen	94,346	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 105,715	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	22,944	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 22,944	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	57,822	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 57,822	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending	8,242	28
28a	Write Off Old Outstanding Checks	21,272	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 29,514	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,693,720	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	819,071	31
32	Health Care	1,908,453	32
33	General Administration	2,114,842	33
	B. Capital Expense		
34	Ownership	1,472,739	34
	C. Ancillary Expense		
35	Special Cost Centers	283,123	35
36	Provider Participation Fee	134,138	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,732,366	40
41	Income before Income Taxes (line 30 minus line 40)**	2,961,354	41
42	Income Taxes	(44,479)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,916,875	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

*** 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 Central Nursing

0019364

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	1,992	2,232	\$ 85,120	\$ 38.14	1
2	Assistant Director of Nursing	1,929	2,168	53,226	24.55	2
3	Registered Nurses	33,237	35,286	909,593	25.78	3
4	Licensed Practical Nurses	5,198	5,794	100,993	17.43	4
5	CNAs & Orderlies	55,598	60,973	567,949	9.31	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,835	7,214	57,425	7.96	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,114	2,274	24,476	10.76	13
14	Head Cook	3,254	3,502	46,222	13.20	14
15	Cook Helpers/Assistants	11,551	12,201	95,682	7.84	15
16	Dishwashers					16
17	Maintenance Workers	2,014	2,254	22,224	9.86	17
18	Housekeepers	16,288	17,730	186,530	10.52	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,687	15,662	261,098	16.67	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)	154,697	167,290	\$ 2,410,538 *	\$ 14.41	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	M	\$ 16,414	1-3	35
36	Medical Director	O			36
37	Medical Records Consultant	N	1,360	10-3	37
38	Nurse Consultant	T			38
39	Pharmacist Consultant	H			39
40	Physical Therapy Consultant	L			40
41	Occupational Therapy Consultant	Y			41
42	Respiratory Therapy Consultant		26,415	10a-3	42
43	Speech Therapy Consultant	F			43
44	Activity Consultant	E			44
45	Social Service Consultant	E	3,236	12.3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 47,425		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,212	\$ 26,667	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,212	\$ 26,667		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
			\$	Workers' Compensation Insurance	\$ 52,244	IDPH License Fee	\$	
				Unemployment Compensation Insurance	25,844	Advertising: Employee Recruitment	9,935	
				FICA Taxes	184,140	Health Care Worker Background Check		
				Employee Health Insurance	424,099	(Indicate # of checks performed 50)	500	
				Employee Meals	12,228	Patient Background Checks	328	
				Illinois Municipal Retirement Fund (IMRF)*		Advertising: Yellow Pages	25,542	
				Chicago Head Tax	4,160	IL Council on Long-Term Care	15,717	
				Union Pension	157,785	Less: Non Deductible Dues	(4,061)	
				Other Employee Benefits	4,000	IL Association of Healthcare Facilities	4,165	
				Allocation from Management	39,143	Schedule Attached	2,510	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	(25,542)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$	TOTAL (agree to Schedule V, line 22, col.8)		\$ 32,046		
			\$ 488,592			\$ 903,643		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees			\$ 488,592			\$	Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 488,592				Seminar Expense	
							Schedule Attached	1,415
C. Professional Services								
Vendor/Payee	Type		Amount				Entertainment Expense	()
Kessler Orlean Silver	Accounting		\$ 15,600				(agree to Sch. V, line 24, col. 8)	
Health Data Systems	Computer Support		2,505				TOTAL	
ADP	Payroll Service		3,533				\$ 1,415	
Accu-Med Services, Inc.	Computer Support		2,640					
Medifax-EDI, LLC	Data Processing		842					
Neal Gerber & Eisenberg	Legal fees		45,000					
Richard Peelo	Healthcare Consultant		4,200					
Personnel Planners, Inc.	Unemployment Consultant		2,182					
Anthony's Mobile Fingerprinting	Fingerprint Residents		460					
Property Valuation Services	Appraisal		2,000					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 78,961	TOTAL		\$		

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Central Nursing

0019364

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

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. Schedule Attached
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (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? _____
- (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. \$ 0 Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 134,138
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? Yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 12,228 Has any meal income been offset against related costs? No Indicate the amount. \$ 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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? None
d. Have vehicle usage logs been maintained? Adequate records are maintained
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
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 The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees