



Facility Name & ID Number CAPITOL CARE CENTER# 0045666 Report Period Beginning: 1/1/07 Ending: 12/31/07

## 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	<u>251</u>	Skilled (SNF)	<u>251</u>	<u>91,615</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>251</u>	TOTALS	<u>251</u>	<u>91,615</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>56,038</u>	<u>660</u>	<u>12,472</u>	<u>69,170</u>	8
9	SNF/PED					9
10	ICF		<u>4,378</u>		<u>4,378</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>56,038</u>	<u>5,038</u>	<u>12,472</u>	<u>73,548</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.28%

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/AF. Does the facility maintain a daily midnight census? YES

G. Do pages 3 &amp; 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 \_\_\_\_\_ 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 12,472Medicare Intermediary ADMINISTAR FEDERAL

## IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number      CAPITOL CARE CENTER      #      0045666      Report Period Beginning:      1/1/07      Ending:      12/31/07

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	360,613	57,016	14,230	431,859		431,859		431,859		1
2	Food Purchase		406,084		406,084		406,084	(20)	406,064		2
3	Housekeeping	172,696	56,117		228,813		228,813		228,813		3
4	Laundry	157,819	46,659	1,681	206,159		206,159		206,159		4
5	Heat and Other Utilities			250,353	250,353		250,353	8,018	258,371		5
6	Maintenance	167,608		169,375	336,983		336,983	8,337	345,320		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>858,736</b>	<b>565,876</b>	<b>435,639</b>	<b>1,860,251</b>		<b>1,860,251</b>	<b>16,335</b>	<b>1,876,586</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			26,100	26,100		26,100		26,100		9
10	Nursing and Medical Records	2,649,781	247,201	28,049	2,925,031		2,925,031		2,925,031		10
10a	Therapy	591,520		39,674	631,194		631,194		631,194		10a
11	Activities	71,149	17,347	4,582	93,078		93,078		93,078		11
12	Social Services	77,938		2,764	80,702		80,702		80,702		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>3,390,388</b>	<b>264,548</b>	<b>101,169</b>	<b>3,756,105</b>		<b>3,756,105</b>		<b>3,756,105</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	102,650		496,000	598,650		598,650	(465,806)	132,844		17
18	Directors Fees										18
19	Professional Services			91,504	91,504		91,504	255	91,759		19
20	Dues, Fees, Subscriptions & Promotions			59,625	59,625		59,625	(27,109)	32,516		20
21	Clerical & General Office Expenses	458,564	50,321	106,840	615,725		615,725	62,839	678,564		21
22	Employee Benefits & Payroll Taxes			933,995	933,995		933,995		933,995		22
23	Inservice Training & Education										23
24	Travel and Seminar			9,991	9,991		9,991		9,991		24
25	Other Admin. Staff Transportation			78,099	78,099		78,099	16,548	94,647		25
26	Insurance-Prop.Liab.Malpractice			269,786	269,786		269,786	1,158	270,944		26
27	Other (specify):*							32,800	32,800		27
28	<b>TOTAL General Administration</b>	<b>561,214</b>	<b>50,321</b>	<b>2,045,840</b>	<b>2,657,375</b>		<b>2,657,375</b>	<b>(379,315)</b>	<b>2,278,060</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>4,810,338</b>	<b>880,745</b>	<b>2,582,648</b>	<b>8,273,731</b>		<b>8,273,731</b>	<b>(362,980)</b>	<b>7,910,751</b>		<b>29</b>

\*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:

1/1/07

Ending:

12/31/07

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			88,842	88,842	88,842	(22,038)	66,804				30
31	Amortization of Pre-Op. & Org.						206	206				31
32	Interest			82,306	82,306	82,306	4,793	87,099				32
33	Real Estate Taxes			112,293	112,293	112,293		112,293				33
34	Rent-Facility & Grounds			898,972	898,972	898,972		898,972				34
35	Rent-Equipment & Vehicles			164,320	164,320	164,320	1,028	165,348				35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,346,733	1,346,733	1,346,733	(16,011)	1,330,722				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			503,113	503,113	503,113		503,113				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			137,800	137,800	137,800		137,800				42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			640,913	640,913	640,913		640,913				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,810,338	880,745	4,570,294	10,261,377	10,261,377	(378,991)	9,882,386				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: 1/1/07

Ending: 12/31/07

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(25,132)	30		9
10	Interest and Other Investment Income	(507)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(20)	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	(8,673)	21		18
19	Entertainment				19
20	Contributions	(16,195)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(8,217)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(24,521)	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	(25,113)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (108,378)		\$	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)	(270,613)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (270,613)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (378,991)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

STATE OF ILLINOIS  
 CAPITOL CARE CENTER

ID# 0045666

Report Period Beginning: 1/1/07

Ending: 12/31/07

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	VENDING INCOME	\$ (1,820)	21	1
2	MISC INCOME	(6,703)	21	2
3	BANK FEES	(9,004)	21	3
4	TAXES-GENERAL	(441)	21	4
5	PRIOR YEAR DEPRECIATION	(1,086)	30	5
6	REAL ESTATE TAXES	(2,996)	33	6
7	IL COUNCIL LTC-COPE	(3,063)	20	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	<b>Total</b>	(25,113)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number CAPITOL CARE CENTER# 0045666

Report Period Beginning:

1/1/07

Ending:

12/31/07

**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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(20)	0	0	0	0	0	0	0	0	0	0	(20)	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	8,018	0	0	0	0	0	0	0	0	8,018	5
6	Maintenance	0	0	8,337	0	0	0	0	0	0	0	0	8,337	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(20)</b>	<b>0</b>	<b>16,355</b>	<b>0</b>	<b>16,335</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	(465,806)	0	0	0	0	0	0	0	0	(465,806)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(8,217)	0	8,472	0	0	0	0	0	0	0	0	255	19
20	Fees, Subscriptions & Promotions	(27,584)	0	475	0	0	0	0	0	0	0	0	(27,109)	20
21	Clerical & General Office Expenses	(42,836)	0	105,675	0	0	0	0	0	0	0	0	62,839	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	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	16,548	0	0	0	0	0	0	0	0	16,548	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,158	0	0	0	0	0	0	0	0	1,158	26
27	Other (specify):*	0	0	32,800	0	0	0	0	0	0	0	0	32,800	27
28	<b>TOTAL General Administration</b>	<b>(78,637)</b>	<b>0</b>	<b>(300,678)</b>	<b>0</b>	<b>(379,315)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(78,657)</b>	<b>0</b>	<b>(284,323)</b>	<b>0</b>	<b>(362,980)</b>	<b>29</b>							

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number CAPITOL CARE CENTER# 0045666

Report Period Beginning:

1/1/07

Ending:

12/31/07

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	(26,218)	0	4,180	0	0	0	0	0	0	0	0	(22,038)	30
31	Amortization of Pre-Op. & Org.	0	0	206	0	0	0	0	0	0	0	0	206	31
32	Interest	(507)	0	5,300	0	0	0	0	0	0	0	0	4,793	32
33	Real Estate Taxes	(2,996)	0	2,996	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	1,028	0	0	0	0	0	0	0	0	1,028	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(29,721)</b>	<b>0</b>	<b>13,710</b>	<b>0</b>	<b>(16,011)</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(108,378)</b>	<b>0</b>	<b>(270,613)</b>	<b>0</b>	<b>(378,991)</b>	<b>45</b>							

Facility Name & ID Number CAPITOL CARE CENTER

# 0045666

Report Period Beginning:

1/1/07

Ending:

12/31/07

**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# 0045666Report Period Beginning: 1/1/07Ending: 12/31/07

## 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	\$ 496,000	Platinum Health Care, LLC	100.00%	\$	(496,000)	15
16	V	5 Utilities		Platinum Health Care, LLC		8,018	8,018	16
17	V	6 Repairs & Maintenance		Platinum Health Care, LLC		8,337	8,337	17
18	V	17 Administrative Salary		Platinum Health Care, LLC		30,194	30,194	18
19	V	19 Professional Fees		Platinum Health Care, LLC		8,472	8,472	19
20	V	20 Fees, Subscriptions		Platinum Health Care, LLC		475	475	20
21	V	21 Clerical Salaries		Platinum Health Care, LLC		88,929	88,929	21
22	V	21 Office Expenses		Platinum Health Care, LLC		16,746	16,746	22
23	V	25 Travel		Platinum Health Care, LLC		16,548	16,548	23
24	V	26 Insurance		Platinum Health Care, LLC		1,158	1,158	24
25	V	27 Employee Benefits		Platinum Health Care, LLC		32,800	32,800	25
26	V	30 Depreciation		Platinum Health Care, LLC		1,143	1,143	26
27	V	35 Equipment Rental		Platinum Health Care, LLC		1,028	1,028	27
28	V	31 Amortization		Platinum Health Care, LLC		206	206	28
29	V	30 Depreciation		Platinum Health Care, LLC		3,037	3,037	29
30	V	32 Interest		Platinum Health Care, LLC		5,300	5,300	30
31	V	33 Real Estate Taxes		Platinum Health Care, LLC		2,996	2,996	31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 496,000			\$ 225,387	\$ * (270,613)	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: 1/1/07 Ending: 12/31/07

## 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	3	7.50	Mgt Fees	\$ 0	1
2	Brian Levinson	Owner	Administrative	33.33	See Attached	7	17.50	Mgt Fees	0	2
3	Mark Shapiro	Owner	Administrative	33.33	See Attached	4	10.00	Mgt Fees	0	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number CAPITOL CARE CENTER

# 0045666

Report Period Beginning:

1/1/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Platinum Health Care, LLC  
 Street Address 7444 Long Ave.  
 City / State / Zip Code Skokie, IL 60077  
 Phone Number ( 847 ) 329-4100  
 Fax Number ( 847 ) 329-7652

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Patient Days	445,050	11	\$ 48,520	\$ 73,548	\$ 8,018	1
2	6	Repairs & Maintenance	Patient Days	445,050	11	50,451	73,548	8,337	2
3	17	Administrative Salary	Patient Days	445,050	11	182,711	182,711	30,194	3
4	19	Professional Fees	Patient Days	445,050	11	51,264	73,548	8,472	4
5	20	Fees, Subscriptions	Patient Days	445,050	11	2,875	73,548	475	5
6	21	Clerical Salaries	Patient Days	445,050	11	538,120	538,120	88,929	6
7	21	Office Expenses	Patient Days	445,050	11	101,335	73,548	16,746	7
8	25	Travel	Patient Days	445,050	11	100,136	73,548	16,548	8
9	26	Insurance	Patient Days	445,050	11	7,006	73,548	1,158	9
10	27	Employee Benefits	Patient Days	445,050	11	198,477	73,548	32,800	10
11	30	Depreciation	Patient Days	445,050	11	6,916	73,548	1,143	11
12	35	Equipment Rental	Patient Days	445,050	11	6,218	73,548	1,028	12
13	31	Amortization	Patient Days	445,050	11	1,246	73,548	206	13
14	30	Depreciation	Patient Days	445,050	11	18,376	73,548	3,037	14
15	32	Interest	Patient Days	445,050	11	32,071	73,548	5,300	15
16	33	Real Estate Taxes	Patient Days	445,050	11	18,130	73,548	2,996	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,363,852	\$ 720,831	\$ 225,387	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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1										1										
2										2										
3										3										
4										4										
5										5										
<b>Working Capital</b>																				
6	Albany Bank & Trust		X	Line of Credit						82,306	6									
7											7									
8											8									
9	<b>TOTAL Facility Related</b>									\$ 82,306	9									
<b>B. Non-Facility Related*</b>																				
10	Interest Income									(507)	10									
11											11									
12											12									
13	Allocation from Platinum									5,300	13									
14	<b>TOTAL Non-Facility Related</b>									\$ 4,793	14									
15	<b>TOTALS (line 9+line14)</b>									\$ 87,099	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.)



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

**2006 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 2006 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 2006.

(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>99,909.96</u>	\$ <u>99,909.96</u>
2. <u>14-28.0-401-006</u>	<u>Long Term Care Property</u>	\$ <u>3,382.90</u>	\$ <u>3,382.90</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>103,292.86</u>	\$ <u>103,292.86</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**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:

1/1/07 Ending:

12/31/07

**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).

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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:

**1/1/07**

Ending:

**12/31/07****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
	<b>Improvement Type**</b>										
9		AWNING		2001	6,950		20	348	348	2,146	9
10		SIGNS & BANNERS		2001	4,354		10	435	435	2,646	10
11		A/C		2002	505		5	65	65	505	11
12		A/C		2002	5,263		7	752	752	4,387	12
13		MASONRY RESTORATION		2002	4,098		10	410	410	2,255	13
14		CEILING WORK		2002	1,500		20	75	75	450	14
15		CEILING WORK		2002	1,835		20	92	92	536	15
16		DOORS		2002	5,665		10	567	567	3,024	16
17		INSTALL GLASS		2002	735		10	74	74	444	17
18		A/C REPAIR		2002	1,202		10	120	120	675	18
19		ELEVATOR REPAIR		2002	2,320		20	116	116	667	19
20		INSTALL GLASS		2002	550		10	55	55	312	20
21		A/C REPAIR		2002	899		10	90	90	487	21
22		FIRE SPRINKLER REPAIR		2002	1,383		10	138	138	748	22
23		WATER PUMP REPAIR		2002	1,566		10	157	157	811	23
24		WATER HEATER		2002	10,018		12	835	835	4,801	24
25		THERMOSTAT REPAIR		2002	2,287		10	229	229	1,336	25
26		THERMOSTAT REPAIR		2002	825		10	83	83	436	26
27		REPAIR KITCHEN EQUIP		2002	1,695		10	170	170	1,020	27
28		INSTALL SIGNS		2002	2,710		10	271	271	1,626	28
29		INSTALL SIGNS		2002	718		10	72	72	432	29
30		ACCESS CONTROL SYSTEM		2002	3,482		10	348	348	2,088	30
31		ACCESS CONTROL SYSTEM		2002	2,646		10	265	265	1,590	31
32		ACCESS CONTROL SYSTEM		2002	588		10	59	59	349	32
33		INSTALL SIGNS		2002	977		10	98	98	571	33
34		SHOWER & GUARD RAILS		2002	535		20	27	27	142	34
35		CALL CORDS		2002	599		20	30	30	170	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:

**1/1/07**

Ending:

**12/31/07****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	\$ 146	37
38	CURTAIN FOR MAIN DINING ROOM	2003	849		5	170	170	779	38
39	REPLACEMENT FOR ZONAIRE	2003	5,565		20	278	278	1,182	39
40	FURNISH & INSTALL NEW CONDENSER	2003	1,521		20	76	76	317	40
41	A/C UNIT	2003	1,100		5	220	220	917	41
42	HOYER LIFT	2003	19,216		10	1,922	1,922	7,848	42
43	NURSES STATION REMODEL	2004	7,877		15	525	525	1,794	43
44	ALTERNATE FLOOR FIRE SVCS	2004	3,255		10	326	326	1,222	44
45	OVERHAUL 2 ELEVATORS	2004	40,080		20	2,004	2,004	7,181	45
46	CARPET	2004	9,720		5	1,944	1,944	6,318	46
47	CONSTRUCT NEW OFFICE SPACE	2005	8,000		27.5	291	291	679	47
48	ZONE RESTRICTOR SYSTEM	2005	5,950		27.5	216	216	522	48
49	CARPET	2005	5,754		5	1,151	1,151	2,494	49
50	FIRE SPRINKLERS	2006	7,867		25	315	315	551	50
51	REPAIRED DRAIN	2006	2,758		20	138	138	241	51
52	10-A/C FAN BLADES	2006	1,001		10	100	100	167	52
53	SOLAR CONTROL WINDOW	2006	1,442		10	144	144	204	53
54	DRIER & CONDENSER	2006	2,093		10	209	209	279	54
55	DRAIN PIPE & SHOWER VALVE	2006	2,277		20	114	114	152	55
56	DOORS	2006	6,806		20	340	340	340	56
57	RED OAK HARDWARE	2007	2,595		20	108	108	108	57
58	PLUMBING REPAIRS AND PART	2007	3,859		20	145	145	145	58
59	REMODEL DOWNSTAIRS LIVING	2007	4,150		15	184	184	184	59
60	REPLACE 4 VALVES AND PIPING	2007	6,011		20	175	175	175	60
61	INSTALL FENCE	2007	1,800		15	60	60	60	61
62	RPR & RSTR PARKING LOT	2007	5,200		15	202	202	202	62
63	CONCRETE REPLACEMENT	2007	8,333		15	324	324	324	63
64	WINDOW TREATMENT	2007	2,489		5	249	249	249	64
65	AIR HANDLER ON 3RD FLOOR	2007	1,025		20	26	26	26	65
66	ROOFTOP A/C SYSTEM	2007	7,305		10	304	304	304	66
67	AIR HANDLER	2007	6,036		20	126	126	126	67
68	CONCRETE REPLACEMENT	2007	9,127		15	203	203	203	68
69	2 A/C UNITS - 3RD & 4TH FLOOR	2007	2,452		5	163	163	163	69
70	TOTAL (lines 4 thru 69)		\$ 259,958	\$		\$ 18,760	\$ 18,760	\$ 70,256	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:

1/1/07

Ending:

12/31/07

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 259,958	\$		\$ 18,760	\$ 18,760	\$ 70,256	1
2	PIPE RAIL	2007	8,250		15	138	138	138	2
3	CONCRETE REPLACEMENT	2007	11,377		15	126	126	126	3
4	ELECTRICAL-OUTSIDE LIGHTS TO CODE	2007	2,328		10	39	39	39	4
5	TVS	2007	5,000		5	167	167	167	5
6	12 BALLASTS	2007	1,133		10	19	19	19	6
7	2ND FLOOR CONSTRUCTION	2007	2,000		15	11	11	11	7
8	CONCRETE FRONT WALL,RAMP,PRKG LOT	2007	28,877		15	160	160	160	8
9	120 LIGHTS	2007	3,098		10				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	Allocation from Platinum Health Care (Bldg & Impr)			1,364		1,364			31
32									32
33				13,003			(13,003)		33
34	TOTAL (lines 1 thru 33)		\$ 322,021	\$ 14,367		\$ 20,784	\$ 6,417	\$ 70,916	34

\*\*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: 1/1/07 Ending: 12/31/07

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	\$ 350,886	\$ 55,694	\$ 36,452	\$ (19,242)		\$ 152,223	71
72	Current Year Purchases	95,293	19,059	6,752	(12,307)		6,752	72
73	Fully Depreciated Assets							73
74	Alloc from Platinum HC		2,816	2,816				74
75	TOTALS	\$ 446,179	\$ 77,569	\$ 46,020	\$ (31,549)		\$ 158,975	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)	\$ 768,200	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 91,936	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 66,804	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (25,132)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 229,891	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: 1/1/07

Ending: 12/31/07

**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>898,972</u>			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$ <u>898,972</u>			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: \$ 114,219 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>51,129</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ _____	\$ <u>51,129</u>	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. /2008 \$ \_\_\_\_\_

13. /2009 \$ \_\_\_\_\_

14. /2010 \$ \_\_\_\_\_

\* 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)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)			
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1		
2	Licensed Speech and Language Development Therapist		hrs							2		
3	Licensed Recreational Therapist		hrs							3		
4	Licensed Physical Therapist	10a-03	hrs			39,674			39,674	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				473,939		473,939	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					29,174		29,174	13		
14	<b>TOTAL</b>			\$		\$	39,674	\$	503,113	\$	542,787	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: 1/1/07 Ending: 12/31/07

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/07 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 7,543	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	3,071,997		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	358,293		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,437,833	\$	10
<b>B. Long-Term Assets</b>				
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	310,225		15
16	Equipment, at Historical Cost	456,301		16
17	Accumulated Depreciation (book methods)	(373,906)		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):	325,688		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 718,308	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,156,141	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 1,506,627	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	250,236		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	105,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Accrued Expenses</u>	300,773		36
37	<u>Due Others &amp; Advance Billing</u>	834,281		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,996,917	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	950,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 950,000	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,946,917	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 209,224	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,156,141	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>886,644</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>886,644</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(364,921)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	(312,499)	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(677,420)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>209,224</b>	<b>24</b> *

\* This must agree with page 17, line 47.

Facility Name & ID Number CAPITOL CARE CENTER# 0045666Report Period Beginning: 1/1/07Ending: 12/31/07**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 7,820,295	1
2	Discounts and Allowances for all Levels	(330,443)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 7,489,852	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,816,665	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,816,665	8
<b>C. Other Operating Revenue</b>			
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	551,733	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	27,789	19
20	Radiology and X-Ray	1,387	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 580,909	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	507	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 507	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>VENDING &amp; MISC INCOME</b>	8,523	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 8,523	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 9,896,456	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,860,251	31
32	Health Care	3,756,105	32
33	General Administration	2,657,375	33
<b>B. Capital Expense</b>			
34	Ownership	1,346,733	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	503,113	35
36	Provider Participation Fee	137,800	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 10,261,377	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(364,921)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (364,921)	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:

1/1/07

Ending:

12/31/07

**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	1,735	1,835	\$ 79,241	\$ 43.18	1
2	Assistant Director of Nursing	11,102	12,269	276,930	22.57	2
3	Registered Nurses	5,505	5,972	127,641	21.37	3
4	Licensed Practical Nurses	44,186	47,644	866,575	18.19	4
5	CNAs & Orderlies	118,378	124,662	1,299,394	10.42	5
6	CNA Trainees					6
7	Licensed Therapist	7,852	8,733	351,324	40.23	7
8	Rehab/Therapy Aides	10,808	12,064	240,196	19.91	8
9	Activity Director	1,875	1,998	24,246	12.14	9
10	Activity Assistants	4,711	5,083	46,903	9.23	10
11	Social Service Workers	4,703	4,902	77,938	15.90	11
12	Dietician					12
13	Food Service Supervisor	1,765	1,965	36,276	18.46	13
14	Head Cook					14
15	Cook Helpers/Assistants	32,893	36,144	324,337	8.97	15
16	Dishwashers					16
17	Maintenance Workers	12,554	13,812	167,608	12.13	17
18	Housekeepers	17,976	19,856	172,696	8.70	18
19	Laundry	14,499	16,073	157,819	9.82	19
20	Administrator	1,805	1,988	102,650	51.63	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	24,812	27,024	458,564	16.97	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)	317,159	342,024	\$ 4,810,338 *	\$ 14.06	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	310	\$ 14,230	01-03	35
36	Medical Director	Monthly	26,100	09-03	36
37	Medical Records Consultant	Monthly	1,620	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	12,929	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	15	377	11-03	44
45	Social Service Consultant	38	2,764	12-03	45
46	Other(specify) <u>Psychiatric Cons</u>		13,500	10-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)	363	\$ 71,520		49

**C. CONTRACT NURSES**

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





Facility Name &amp; ID Number CAPITOL CARE CENTER

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. IL COUNCIL LTC \$13,283
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,250 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (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. \$ 137,800  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? Yes  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? \_\_\_\_\_  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? \_\_\_\_\_  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees.