

Facility Name & ID Number CAPITOL CARE CENTER

0045666 Report Period Beginning: 1/01/08 Ending: 12/31/08

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	251	Skilled (SNF)	251	91,866	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	251	TOTALS	251	91,866	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	55,823	807	16,033	72,663	8
9	SNF/PED					9
10	ICF		4,179		4,179	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	55,823	4,986	16,033	76,842	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.65%

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

None (Do not include bed-hold days in Section B.)

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

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

N/A

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

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

YES NO

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

YES NO

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

Date started 10/01/01

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

YES Date 10/01/01 NO

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

YES NO If YES, enter number of beds certified 251 and days of care provided 16,033

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 1/01/08 Ending: 12/31/08

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	378,234	39,317	17,438	434,989		434,989		434,989		1
2	Food Purchase		434,404		434,404		434,404	(20)	434,384		2
3	Housekeeping	218,682	59,304		277,986		277,986		277,986		3
4	Laundry	159,205	33,279		192,484		192,484		192,484		4
5	Heat and Other Utilities			286,618	286,618		286,618	8,075	294,693		5
6	Maintenance	185,785		208,852	394,637		394,637	7,177	401,814		6
7	Other (specify):*										7
8	TOTAL General Services	941,906	566,304	512,908	2,021,118		2,021,118	15,232	2,036,350		8
	B. Health Care and Programs										
9	Medical Director			29,100	29,100		29,100		29,100		9
10	Nursing and Medical Records	2,962,533	306,943	32,340	3,301,816		3,301,816		3,301,816		10
10a	Therapy	741,124		83,825	824,949		824,949		824,949		10a
11	Activities	66,215	11,532	7,159	84,906		84,906		84,906		11
12	Social Services	92,722		1,682	94,404		94,404		94,404		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,862,594	318,475	154,106	4,335,175		4,335,175		4,335,175		16
	C. General Administration										
17	Administrative	138,284		480,000	618,284		618,284	(435,328)	182,956		17
18	Directors Fees										18
19	Professional Services			120,841	120,841		120,841	(557)	120,284		19
20	Dues, Fees, Subscriptions & Promotions			77,318	77,318		77,318	(37,994)	39,324		20
21	Clerical & General Office Expenses	373,532	59,253	111,179	543,964		543,964	76,960	620,924		21
22	Employee Benefits & Payroll Taxes			1,054,270	1,054,270		1,054,270		1,054,270		22
23	Inservice Training & Education										23
24	Travel and Seminar			16,536	16,536		16,536	760	17,296		24
25	Other Admin. Staff Transportation			77,570	77,570		77,570	(3,629)	73,941		25
26	Insurance-Prop.Liab.Malpractice			263,936	263,936		263,936	(1,456)	262,480		26
27	Other (specify):*							28,553	28,553		27
28	TOTAL General Administration	511,816	59,253	2,201,650	2,772,719		2,772,719	(372,691)	2,400,028		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,316,316	944,032	2,868,664	9,129,012		9,129,012	(357,459)	8,771,553		29

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

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

Facility Name & ID Number CAPITOL CARE CENTER

#0045666

Report Period Beginning:

1/01/08

Ending:

12/31/08

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			192,976	192,976		192,976	(107,210)	85,766			30
31	Amortization of Pre-Op. & Org.							183	183			31
32	Interest			77,969	77,969		77,969	4,426	82,395			32
33	Real Estate Taxes			100,784	100,784		100,784		100,784			33
34	Rent-Facility & Grounds			921,876	921,876		921,876		921,876			34
35	Rent-Equipment & Vehicles			214,299	214,299		214,299	910	215,209			35
36	Other (specify):*											36
37	TOTAL Ownership			1,507,904	1,507,904		1,507,904	(101,691)	1,406,213			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			575,629	575,629		575,629		575,629			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):*							(54,306)	(54,306)			43
44	TOTAL Special Cost Centers			713,429	713,429		713,429	(54,306)	659,123			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,316,316	944,032	5,089,997	11,350,345		11,350,345	(513,456)	10,836,889			45

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

Facility Name & ID Number CAPITOL CARE CENTER

0045666

Report Period Beginning: 1/01/08

Ending: 12/31/08

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	(111,029)	30		9
10	Interest and Other Investment Income	(235)	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	(22,809)	21		18
19	Entertainment				19
20	Contributions	(16,903)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(11,087)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(30,382)	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	(87,687)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (280,152)		\$	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)	(233,304)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (233,304)		36
37	TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)	\$ (513,456)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

CAPITOL CARE CENTER

ID# 0045666

Report Period Beginning: 1/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	VENDING INCOME	\$ (961)	21	1
2	TRANSPORTATION INCOME	(2,250)	6	2
3	MISCELLANEOUS INCOME	35	21	3
4	MISC INCOME-INSURANCE DIVIDEND	(2,685)	26	4
5	MISC INCOME-CORPORATE HR ALLOC	(22,000)	43	5
6	TAXES-GENERAL	(956)	21	6
7	DAMAGE/LOSS/THEFT	(1,672)	21	7
8	IL COUNCIL LTC-COPE	(8,786)	20	8
9	REAL ESTATE TAXES	(3,484)	33	9
10	PH ECLIPSE AIRPLANE EXPENSE	(12,622)	25	10
11	MARKETING SALARIES	(26,960)	43	11
12	MARKETING EMPLOYEE BENEFITS	(5,346)	43	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	(87,687)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CAPITOL CARE CENTER

0045666

Report Period Beginning:

1/01/08

Ending:

12/31/08

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(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	8,075	0	0	0	0	0	0	0	0	8,075	5
6	Maintenance	(2,250)	0	9,427	0	0	0	0	0	0	0	0	7,177	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,270)	0	17,502	0	15,232	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(435,328)	0	0	0	0	0	0	0	0	(435,328)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(11,087)	0	10,530	0	0	0	0	0	0	0	0	(557)	19
20	Fees, Subscriptions & Promotions	(39,168)	0	1,174	0	0	0	0	0	0	0	0	(37,994)	20
21	Clerical & General Office Expenses	(43,266)	0	120,226	0	0	0	0	0	0	0	0	76,960	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	760	0	0	0	0	0	0	0	0	760	24
25	Other Admin. Staff Transportation	(12,622)	0	8,993	0	0	0	0	0	0	0	0	(3,629)	25
26	Insurance-Prop.Liab.Malpractice	(2,685)	0	1,229	0	0	0	0	0	0	0	0	(1,456)	26
27	Other (specify):*	0	0	28,553	0	0	0	0	0	0	0	0	28,553	27
28	TOTAL General Administration	(108,828)	0	(263,863)	0	(372,691)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(111,098)	0	(246,361)	0	(357,459)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CAPITOL CARE CENTER# 0045666 Report Period Beginning:

1/01/08 Ending:

12/31/08

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(111,029)	0	3,819	0	0	0	0	0	0	0	0	(107,210)	30
31	Amortization of Pre-Op. & Org.	0	0	183	0	0	0	0	0	0	0	0	183	31
32	Interest	(235)	0	4,661	0	0	0	0	0	0	0	0	4,426	32
33	Real Estate Taxes	(3,484)	0	3,484	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	910	0	0	0	0	0	0	0	0	910	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(114,748)	0	13,057	0	(101,691)	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):*	(54,306)	0	0	0	0	0	0	0	0	0	0	(54,306)	43
44	TOTAL Special Cost Centers	(54,306)	0	0	0	0	0	0	0	0	0	0	(54,306)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(280,152)	0	(233,304)	0	(513,456)	45							

Facility Name & ID Number CAPITOL CARE CENTER

0045666

Report Period Beginning:

1/01/08

Ending:

12/31/08

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		\$			\$	\$
2	V						
3	V						
4	V						
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$			\$	\$ *

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

Facility Name & ID Number CAPITOL CARE CENTER# 0045666Report Period Beginning: 1/01/08Ending: 12/31/08

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	\$ 480,000	Platinum Health Care, LLC	100.00%	\$	(480,000)	15
16	V	5 Utilities		Platinum Health Care, LLC		8,075	8,075	16
17	V	6 Repairs & Maintenance		Platinum Health Care, LLC		9,427	9,427	17
18	V	17 Administrative Salary		Platinum Health Care, LLC		44,672	44,672	18
19	V	19 Professional Fees		Platinum Health Care, LLC		10,530	10,530	19
20	V	20 Fees, Subscriptions		Platinum Health Care, LLC		1,174	1,174	20
21	V	21 Clerical Salaries		Platinum Health Care, LLC		107,128	107,128	21
22	V	21 Office Expenses		Platinum Health Care, LLC		13,098	13,098	22
23	V	24 Education & Seminars		Platinum Health Care, LLC		760	760	23
24	V	25 Travel		Platinum Health Care, LLC		8,993	8,993	24
25	V	26 Insurance		Platinum Health Care, LLC		1,229	1,229	25
26	V	27 Employee Benefits		Platinum Health Care, LLC		28,553	28,553	26
27	V	30 Depreciation		Platinum Health Care, LLC		1,111	1,111	27
28	V	35 Equipment Rental		Platinum Health Care, LLC		910	910	28
29	V	31 Amortization		Platinum Health Care, LLC		183	183	29
30	V	30 Depreciation		Platinum Health Care, LLC		2,708	2,708	30
31	V	32 Interest		Platinum Health Care, LLC		4,661	4,661	31
32	V	33 Real Estate Taxes		Platinum Health Care, LLC		3,484	3,484	32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 480,000			\$ 246,696	\$ * (233,304)	39

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

Facility Name & ID Number

CAPITOL CARE CENTER

#

0045666

Report Period Beginning:

1/01/08

Ending:

12/31/08

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		Administrative	33.33	SEE ATTACHED	3	7.50	Mgt Fees	\$	1
2	Brian Levinson		Administrative	33.33	SEE ATTACHED	7	17.50	Mgt Fees		2
3	Mark Shapiro		Administrative	33.33	SEE ATTACHED	2	5.00	Mgt Fees		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:

1/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Platinum 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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Patient Days	522,253	12	\$ 54,883	\$ 76,842	\$ 8,075	1
2	6	Repairs & Maintenance	Patient Days	522,253	12	64,073	76,842	9,427	2
3	17	Administrative Salary	Patient Days	522,253	12	303,614	303,614	44,672	3
4	19	Professional Fees	Patient Days	522,253	12	71,566	76,842	10,530	4
5	20	Fees, Subscriptions	Patient Days	522,253	12	7,979	76,842	1,174	5
6	21	Clerical Salaries	Patient Days	522,253	12	728,090	728,090	107,128	6
7	21	Office Expenses	Patient Days	522,253	12	89,019	76,842	13,098	7
8	24	Education & Seminars	Patient Days	522,253	12	5,163	76,842	760	8
9	25	Travel	Patient Days	522,253	12	61,119	76,842	8,993	9
10	26	Insurance	Patient Days	522,253	12	8,354	76,842	1,229	10
11	27	Employee Benefits	Patient Days	522,253	12	194,056	76,842	28,553	11
12	30	Depreciation	Patient Days	522,253	12	7,547	76,842	1,111	12
13	35	Equipment Rental	Patient Days	522,253	12	6,184	76,842	910	13
14	31	Amortization	Patient Days	522,253	12	1,246	76,842	183	14
15	30	Depreciation	Patient Days	522,253	12	18,405	76,842	2,708	15
16	32	Interest	Patient Days	522,253	12	31,679	76,842	4,661	16
17	33	Real Estate Taxes	Patient Days	522,253	12	23,679	76,842	3,484	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,676,656	\$ 1,031,704	\$ 246,696	25

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 1/01/08 Ending: 12/31/08

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6	Fifth Third Bank		X	Line of Credit				1,680,000		77,969	6									
7										7										
8										8										
9	TOTAL Facility Related							\$ 1,680,000		\$ 77,969	9									
B. Non-Facility Related*																				
10	Interest Income									(235)	10									
11											11									
12											12									
13	Allocation from Platinum									4,661	13									
14	TOTAL Non-Facility Related									\$ 4,426	14									
15	TOTALS (line 9+line14)							\$ 1,680,000		\$ 82,395	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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>97,336.18</u>	\$ <u>97,336.18</u>
2. <u>14-28.0-401-006</u>	<u>Long Term Care Property</u>	\$ <u>3,447.72</u>	\$ <u>3,447.72</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>100,783.90</u>	\$ <u>100,783.90</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

Facility Name & ID Number CAPITOL CARE CENTER

0045666 Report Period Beginning:

1/01/08 Ending:

12/31/08

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

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

Report Period Beginning:

1/01/08

Ending:

12/31/08

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		AWNING		2001	6,950		20	348	348	2,494	9
10		SIGNS & BANNERS		2001	4,354		10	435	435	3,081	10
11		A/C		2002	505		5	101	101	606	11
12		A/C		2002	5,263		7	752	752	5,139	12
13		MASONRY RESTORATION		2002	4,098		10	410	410	2,665	13
14		CEILING WORK		2002	1,500		20	75	75	525	14
15		CEILING WORK		2002	1,835		20	92	92	628	15
16		DOORS		2002	5,665		10	567	567	3,591	16
17		INSTALL GLASS		2002	735		10	74	74	518	17
18		A/C REPAIR (REMOVE \$1,202 PER 2008 CAP COST AUDIT)		2002			10				18
19		ELEVATOR REPAIR		2002	2,320		20	116	116	783	19
20		INSTALL GLASS		2002	550		10	55	55	367	20
21		A/C REPAIR (REMOVE \$899 PER 2008 CAP COST AUDIT)		2002			10				21
22		FIRE SPRINKLER REPAIR (REMOVE \$1,383 PER 2008 CAP COST AU		2002			10				22
23		WATER PUMP REPAIR		2002	1,566		10	157	157	968	23
24		WATER HEATER		2002	10,018		12	835	835	5,636	24
25		THERMOSTAT REPAIR		2002	2,287		10	229	229	1,565	25
26		THERMOSTAT REPAIR		2002	825		10	83	83	519	26
27		REPAIR KITCHEN EQUIP (RECLASS \$1,695 TO MME PER 2008 CAP		2002			10				27
28		INSTALL SIGNS		2002	2,710		10	271	271	1,897	28
29		INSTALL SIGNS		2002	718		10	72	72	504	29
30		ACCESS CONTROL SYSTEM		2002	3,482		10	348	348	2,436	30
31		ACCESS CONTROL SYSTEM		2002	2,646		10	265	265	1,855	31
32		ACCESS CONTROL SYSTEM		2002	588		10	59	59	408	32
33		INSTALL SIGNS		2002	977		10	98	98	669	33
34		SHOWER & GUARD RAILS		2002	535		20	27	27	169	34
35		CALL CORDS		2002	599		20	30	30	200	35
36											36

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

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

See Page 12A, Line 70 for total

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

Report Period Beginning:

1/01/08

Ending:

12/31/08

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	\$ 173	37
38	CURTAIN FOR MAIN DINING ROOM	2003	849		5	170	170	949	38
39	REPLACEMENT FOR ZONAIRE	2003	5,565		20	278	278	1,460	39
40	FURNISH & INSTALL NEW CONDENSER	2003	1,521		20	76	76	393	40
41	A/C UNIT	2003	1,100		5	220	220	1,137	41
42	HOYER LIFT (RECLASS \$19,216 TO MME PER CAP COST AU	2003			10				42
43	NURSES STATION REMODEL	2004	7,877		15	525	525	2,319	43
44	ALTERNATE FLOOR FIRE SVCS	2004	3,255		10	326	326	1,548	44
45	OVERHAUL 2 ELEVATORS	2004	40,080		20	2,004	2,004	9,185	45
46	CARPET	2004	9,720		5	1,944	1,944	8,262	46
47	CONSTRUCT NEW OFFICE SPACE (REMOVE \$8,000 PER 2008	2005			27.5				47
48	ZONE RESTRICTOR SYSTEM	2005	5,950		27.5	216	216	738	48
49	CARPET	2005	5,754		5	1,151	1,151	3,645	49
50	FIRE SPRINKLERS	2006	7,867		25	315	315	866	50
51	REPAIRED DRAIN	2006	2,758		20	138	138	379	51
52	10-A/C FAN BLADES	2006	1,001		10	100	100	267	52
53	SOLAR CONTROL WINDOW	2006	1,442		10	144	144	348	53
54	DRIER & CONDENSER	2006	2,093		10	209	209	488	54
55	DRAIN PIPE & SHOWER VALVE	2006	2,277		20	114	114	266	55
56	DOORS	2006	6,806		20	340	340	680	56
57	RED OAK HARDWARE	2007	2,595		20	130	130	238	57
58	PLUMBING REPAIRS AND PART	2007	3,859		20	193	193	338	58
59	REMODEL DOWNSTAIRS LIVING (REMOVE \$4,150 PER 2008	2007			15				59
60	REPLACE 4 VALVES AND PIPING	2007	6,011		20	301	301	476	60
61	INSTALL FENCE (REMOVE \$1,800 PER 2008 CAP COST AUDI	2007			15				61
62	RPR & RSTR PARKING LOT	2007	5,200		15	347	347	549	62
63	CONCRETE REPLACEMENT	2007	8,333		15	556	556	880	63
64	WINDOW TREATMENT (REMOVE \$2,489 PER 2008 CAP COS	2007			5				64
65	AIR HANDLER ON 3RD FLOOR (REMOVE \$1,025 PER 2008 CA	2007			20				65
66	ROOFTOP A/C SYSTEM	2007	7,305		10	731	731	1,035	66
67	AIR HANDLER	2007	6,036		20	302	302	428	67
68	CONCRETE REPLACEMENT	2007	9,127		15	608	608	811	68
69	2 A/C UNITS - 3RD & 4TH FL (REMOVE \$2,452 PER 2008 CAP	2007			5				69
70	TOTAL (lines 4 thru 69)		\$ 215,647	\$		\$ 16,964	\$ 16,964	\$ 75,081	70

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

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

Report Period Beginning:

1/01/08

Ending:

12/31/08

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		\$ 215,647	\$		\$ 16,964	\$ 16,964	\$ 75,081	1
2	<u>PIPE RAIL</u>	2007	8,250		15	550	550	688	2
3	<u>CONCRETE REPLACEMENT</u>	2007	11,377		15	758	758	884	3
4	<u>ELECTRICAL-OUTSIDE LIGHTS TO CODE</u>	2007	2,328		10	233	233	272	4
5	<u>TVS</u>	2007	5,000		5	1,000	1,000	1,167	5
6	<u>12 BALLASTS (REMOVE \$1,133 PER 2008 CAP COST AUDIT)</u>	2007			10				6
7	<u>2ND FLOOR CONSTRUCTION (REMOVE \$2,000 PER 2008 CAI</u>	2007			15				7
8	<u>CONCRETE FRONT WALL,RAMP,PRKG LOT</u>	2007	28,877		15	1,925	1,925	2,085	8
9	<u>120 LIGHTS</u>	2007	3,098		10	310	310	310	9
10	<u>FOOTINGS/CONCRETE RETAINING WALLS</u>	2008	22,994		20	383	383	383	10
11	<u>35' RETAINING WALL</u>	2008	7,350		15	82	82	82	11
12	<u>REMOVE/REBUILD WALL IN BUSINESS OFFICE</u>	2008	1,500		15	75	75	75	12
13	<u>VINYL FLOORING</u>	2008	56,535		10	4,240	4,240	4,240	13
14	<u>WAINSCOTING IN DINING AREA</u>	2008	30,050		15	835	835	835	14
15	<u>REPLACE 10 CHANDELIERS</u>	2008	3,487		10	320	320	320	15
16	<u>TV RESIDENCE ROOMS</u>	2008	2,000		10	150	150	150	16
17	<u>(6) 23" LCD/(1) 26" LCD & TV MOUNTS</u>	2008	2,791		10	209	209	209	17
18	<u>(14) SHELF WHT WIRE & CLIPS (REMOVE \$1,052 PER 2008 C</u>	2008			15				18
19	<u>(4)LOCKNETICS DOOR MAGNETS</u>	2008	5,230		10	349	349	349	19
20	<u>(2) LOCKNETICS DOOR MAGNETS</u>	2008	2,446		10	122	122	122	20
21	<u>INDOOR KEYPAD/EXIT SENSOR</u>	2008	3,255		10	81	81	81	21
22	<u>KEYPAD ACCESS, CAMERA & MULTIPLEXER</u>	2008	5,159		10	43	43	43	22
23	<u>TILE - BACK SPLASH (REMOVE \$1,260 PER 2008 CAP COST A</u>	2008			10				23
24	<u>(4) 23" LCD TV, (3) MOUNTS</u>	2008	1,552		10	91	91	91	24
25	<u>(34) CUBICLE CURTAINS</u>	2008	2,680		5	313	313	313	25
26	<u>ASCOWITCH AUTO TRANSFER SWITCH</u>	2008	2,623		15	102	102	102	26
27	<u>(6) ZONELINE HEAT/COOL</u>	2008	4,176		15	162	162	162	27
28	<u>(3) CHANDELIERS/(1) FAN (REMOVE \$1,289 PER 2008 CAP CO</u>	2008			10				28
29	<u>(3) AC UNITS</u>	2008	7,020		15	234	234	234	29
30	<u>COMPRESSOR 12,000 BTU</u>	2008	2,163		12	90	90	90	30
31	<u>STAINLESS STEEL RECEIVER ON WALK-IN COOLER</u>	2008	1,600		10	80	80	80	31
32	<u>CEMENT/BLACKTOP</u>	2008	2,500		8	130	130	130	32
33	<u>SINK/DRAIN PIPING</u>	2008	2,195		10	110	110	110	33
34	TOTAL (lines 1 thru 33)		\$ 443,883	\$		\$ 29,941	\$ 29,941	\$ 88,688	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:

1/01/08

Ending:

12/31/08

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 443,883	\$		\$ 29,941	\$ 29,941	\$ 88,688	1
2	LIGHT BULBS	2008	4,914		5	491	491	491	2
3	TRANSFER SWITCH	2008	1,354		15	53	53	53	3
4	A/C WORK	2008	5,781		15	225	225	225	4
5	LIGHT FIXTURES	2008	1,578		10	79	79	79	5
6	(34) CUBICLE CURTAINS	2008	2,680		5	268	268	268	6
7	ROUTER/PRINTER/INSTALL	2008	5,179		5	432	432	432	7
8	CARPET	2008	432		5	344	344	344	8
9	FRONT RAILING	2008	15,466		15	344	344	344	9
10	(25) FO32T8/SUPER 741	2008	3,000		15	50	50	50	10
11	DOOR PARTS--CLOSERS/HINGES	2008	1,590		20	20	20	20	11
12	ROCK FOR PARKING LOT & LANDSCAPING	2008	535		5	18	18	18	12
13	KITCHEN DOOR	2008	1,008		20	13	13	13	13
14	DOORS - 2ND FLOOR	2008	885		15	10	10	10	14
15	42" DOOR W/SIDELITE	2008	4,401		15	49	49	49	15
16	DOOR OPERATOR BY STANLEY	2008	2,805		15	31	31	31	16
17	ARCHITECTURAL SERVICES	2008	3,600		20				17
18				86,268			(86,268)		18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30	Allocation from Platinum Health Care (Bldg & Impr)			1,240		1,240			30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 499,091	\$ 87,508		\$ 33,608	\$ (53,900)	\$ 91,115	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: 1/01/08 Ending: 12/31/08

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	\$ 467,091	\$ 63,247	\$ 45,701	\$ (17,546)		\$ 224,147	71
72	Current Year Purchases	72,435	43,461	3,878	(39,583)		3,878	72
73	Fully Depreciated Assets							73
74	Allocation from PHC		2,579	2,579				74
75	TOTALS	\$ 539,526	\$ 109,287	\$ 52,158	\$ (57,129)		\$ 228,025	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)	\$ 1,038,617	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 196,795	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 85,766	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (111,029)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 319,140	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number CAPITOL CARE CENTER

0045666

Report Period Beginning: 1/01/08

Ending: 12/31/08

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>921,876</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ <u>921,876</u>			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	<u>2009</u>	\$ _____
13.	<u>2010</u>	\$ _____
14.	<u>2011</u>	\$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 130,214 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>73,356</u>	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ <u>73,356</u>	21

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

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

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 1/01/08 Ending: 12/31/08

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	10a-03	hrs		1,394	83,825		1,394	83,825	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				544,840		544,840	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>Lab & X-ray</u>	39-02					30,789		30,789	13
14	TOTAL			\$	1,394	\$ 83,825	\$ 575,629	1,394	\$ 659,454	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# 0045666Report Period Beginning: 1/01/08

Ending:

12/31/08**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/08

(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	\$ (224,036)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	4,480,117		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	337,198		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,593,279	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	542,038		15
16	Equipment, at Historical Cost	528,737		16
17	Accumulated Depreciation (book methods)	(566,880)		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):	563,431		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,067,326	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,660,605	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,838,902	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	289,887		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
	Other Current Liabilities(specify):			
36	<u>Accrued Expenses</u>	253,157		36
37	<u>Due Others & Adv Billing</u>	933,440		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,420,386	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,680,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,680,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,100,386	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 560,219	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,660,605	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 209,224	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 209,225	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	350,994	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 350,994	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)	\$ 560,219	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number CAPITOL CARE CENTER

0045666

Report Period Beginning: 1/01/08

Ending: 12/31/08

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	\$ 8,793,707	1
2	Discounts and Allowances for all Levels	(656,260)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,137,447	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,844,840	6
7	Oxygen	9,502	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,854,342	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	650,665	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	29,434	19
20	Radiology and X-Ray	1,355	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 681,454	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	235	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 235	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	TRANSPORTATION, VENDING, MISC INC	27,861	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 27,861	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,701,339	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,021,118	31
32	Health Care	4,335,175	32
33	General Administration	2,772,719	33
B. Capital Expense			
34	Ownership	1,507,904	34
C. Ancillary Expense			
35	Special Cost Centers	575,629	35
36	Provider Participation Fee	137,800	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,350,345	40
41	Income before Income Taxes (line 30 minus line 40)**	350,994	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 350,994	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. Tax Return Filed on Cash Basis

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

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

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

0045666

Report Period Beginning:

1/01/08

Ending:

12/31/08

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	1,913	1,987	\$ 97,556	\$ 49.10	1
2	Assistant Director of Nursing	11,287	12,764	300,885	23.57	2
3	Registered Nurses	14,846	15,629	335,677	21.48	3
4	Licensed Practical Nurses	39,440	42,636	829,350	19.45	4
5	CNAs & Orderlies	121,271	127,247	1,365,351	10.73	5
6	CNA Trainees					6
7	Licensed Therapist	7,265	7,650	348,687	45.58	7
8	Rehab/Therapy Aides	16,473	17,953	392,437	21.86	8
9	Activity Director	1,849	1,987	24,354	12.26	9
10	Activity Assistants	4,210	4,433	41,861	9.44	10
11	Social Service Workers	5,434	6,034	92,722	15.37	11
12	Dietician					12
13	Food Service Supervisor	1,824	1,980	36,854	18.61	13
14	Head Cook					14
15	Cook Helpers/Assistants	32,352	34,754	341,380	9.82	15
16	Dishwashers					16
17	Maintenance Workers	16,143	17,680	185,785	10.51	17
18	Housekeepers	22,751	24,805	218,682	8.82	18
19	Laundry	13,411	15,174	159,205	10.49	19
20	Administrator	1,913	1,987	138,284	69.59	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	21,491	23,162	373,532	16.13	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,903	2,057	33,714	16.39	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	335,776	359,919	\$ 5,316,316 *	\$ 14.77	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	343	\$ 16,902	01-03	35
36	Medical Director	Monthly	29,100	09-03	36
37	Medical Records Consultant	Monthly	1,760	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant		12,580	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	29	1,682	12-03	45
46	Other(specify) <u>Psychiatric Cons</u>		18,000	10-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)	372	\$ 80,024		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 & 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 \$17,369
- (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? 10-15 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,463 Line 10-2
- (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. \$ _____
- (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.