

Facility Name & ID Number Central Nursing

0019364 Report Period Beginning: 01/01/2008 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 245

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>245</u>	Skilled (SNF)	<u>245</u>	<u>89,670</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>245</u>	TOTALS	<u>245</u>	<u>89,670</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>80,921</u>	<u>118</u>	<u>4,982</u>	<u>86,021</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>80,921</u>	<u>118</u>	<u>4,982</u>	<u>86,021</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.93%

D. How many bed-hold days during this year were paid by the Department? 2,128 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

N/A

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 01/01/1973

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 22 and days of care provided 3,765

Medicare Intermediary Mutual Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2008 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	162,142	27,797	17,220	207,159		207,159	49,500	256,659		1
2	Food Purchase		209,302		209,302	(29,936)	179,366	(373)	178,993		2
3	Housekeeping	200,964	19,567		220,531		220,531		220,531		3
4	Laundry		7,295		7,295		7,295		7,295		4
5	Heat and Other Utilities			199,406	199,406		199,406	4,396	203,802		5
6	Maintenance	24,302	35,087	2,198	61,587		61,587	39,419	101,006		6
7	Other (specify):* See Attached Sch			16,296	16,296		16,296		16,296		7
8	TOTAL General Services	387,408	299,048	235,120	921,576	(29,936)	891,640	92,942	984,582		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,538,015	87,088	267,317	1,892,420		1,892,420		1,892,420		10
10a	Therapy			7,512	7,512		7,512		7,512		10a
11	Activities	69,188	369		69,557		69,557		69,557		11
12	Social Services			3,588	3,588		3,588		3,588		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,607,203	87,457	278,417	1,973,077		1,973,077		1,973,077		16
	C. General Administration										
17	Administrative			576,899	576,899		576,899	(266,671)	310,228		17
18	Directors Fees										18
19	Professional Services			52,167	52,167		52,167	6,766	58,933		19
20	Dues, Fees, Subscriptions & Promotions			32,063	32,063		32,063	(3,071)	28,992		20
21	Clerical & General Office Expenses	261,489		17,940	279,429		279,429	124,296	403,725		21
22	Employee Benefits & Payroll Taxes			404,640	404,640	29,936	434,576	40,465	475,041		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,425	2,425		2,425		2,425		24
25	Other Admin. Staff Transportation			2,417	2,417		2,417	(318)	2,099		25
26	Insurance-Prop.Liab.Malpractice			133,404	133,404		133,404	492	133,896		26
27	Other (specify):* Bad Debts			32,983	32,983		32,983	(32,983)			27
28	TOTAL General Administration	261,489		1,254,938	1,516,427	29,936	1,546,363	(131,024)	1,415,339		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,256,100	386,505	1,768,475	4,411,080		4,411,080	(38,082)	4,372,998		29

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

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

Facility Name & ID Number

Central Nursing

#0019364

Report Period Beginning:

01/01/2008

Ending:

12/31/08

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			24,148	24,148		24,148	39,522	63,670			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			9,394	9,394	243,128	252,522		252,522			33
34	Rent-Facility & Grounds			1,450,366	1,450,366	(243,128)	1,207,238	(1,207,238)				34
35	Rent-Equipment & Vehicles			2,172	2,172		2,172	501	2,673			35
36	Other (specify):*											36
37	TOTAL Ownership			1,486,080	1,486,080		1,486,080	(1,167,215)	318,865			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		247,805	255	248,060		248,060		248,060			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			134,506	134,506		134,506		134,506			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		247,805	134,761	382,566		382,566		382,566			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,256,100	634,310	3,389,316	6,279,726		6,279,726	(1,205,297)	5,074,429			45

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

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	39,313	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(373)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(370)	25		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(300)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(32,983)	27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,148)	20		28
29	Other-Attach Schedule	805			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 1,944		\$	30

BHF USE ONLY							
48		49		50		51	

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)			34
35	Other- Attach Schedule	(1,207,241)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,207,241)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,205,297)		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

Central Nursing

ID# 0019364

Report Period Beginning: 01/01/2008

Ending: 12/31/08

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Background Checks paid by Balmoral	\$		1
2	Home (related entity)	525	20	2
3	Franchise Tax	(100)	21	3
4	Background Checks paid by related entity	380	20	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	805		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Central Nursing# 0019364

Report Period Beginning:

01/01/2008

Ending:

12/31/08

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	49,500	0	0	0	0	0	0	0	0	49,500	1
2	Food Purchase	(373)	0	0	0	0	0	0	0	0	0	0	(373)	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	4,396	0	0	0	0	0	0	0	0	0	4,396	5
6	Maintenance	0	2,204	37,215	0	0	0	0	0	0	0	0	39,419	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(373)	6,600	86,715	0	92,942	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	(576,899)	310,228	0	0	0	0	0	0	0	0	(266,671)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	6,766	0	0	0	0	0	0	0	0	6,766	19
20	Fees, Subscriptions & Promotions	(3,243)	130	42	0	0	0	0	0	0	0	0	(3,071)	20
21	Clerical & General Office Expenses	(400)	1,854	122,842	0	0	0	0	0	0	0	0	124,296	21
22	Employee Benefits & Payroll Taxes	0	40,465	0	0	0	0	0	0	0	0	0	40,465	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	(370)	52	0	0	0	0	0	0	0	0	0	(318)	25
26	Insurance-Prop.Liab.Malpractice	0	492	0	0	0	0	0	0	0	0	0	492	26
27	Other (specify):*	(32,983)	0	0	0	0	0	0	0	0	0	0	(32,983)	27
28	TOTAL General Administration	(36,996)	(533,906)	439,878	0	(131,024)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(37,369)	(527,306)	526,593	0	(38,082)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Central Nursing

0019364

Report Period Beginning:

01/01/2008

Ending:

12/31/08

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	39,313	0	209	0	0	0	0	0	0	0	0	39,522	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(1,207,238)	0	0	0	0	0	0	0	0	(1,207,238)	34
35	Rent-Equipment & Vehicles	0	501	0	0	0	0	0	0	0	0	0	501	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	39,313	501	(1,207,029)	0	(1,167,215)	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,944	(526,805)	(680,436)	0	(1,205,297)	45							

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Marvin Mermelstein	50.00	Winston Manor Nursing Home	Chicago	Nivram Mng, Inc.	Lincolnwood	Management
Joseph Mermelstein	50.00	Balmoral Home, Inc.	Chicago			
		Chicago Ridge Nursing Center	Chicago Ridge			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 Management Fees	\$ 576,899	Nivram Management, Inc.	50.00%	\$	(576,899)	1
2	V	21 Delivery Expense		Nivram Management, Inc.	50.00%	622	622	2
3	V	21 Office Expense		Nivram Management, Inc.	50.00%	1,204	1,204	3
4	V	20 Dues & Subscriptions		Nivram Management, Inc.	50.00%	130	130	4
5	V	21 Franchise Tax		Nivram Management, Inc.	50.00%	28	28	5
6	V	22 Payroll Taxes		Nivram Management, Inc.	50.00%	36,944	36,944	6
7	V	5 Utilities		Nivram Management, Inc.	50.00%	4,396	4,396	7
8	V	26 Insurance		Nivram Management, Inc.	50.00%	492	492	8
9	V	6 Repair & Maintenance		Nivram Management, Inc.	50.00%	2,052	2,052	9
10	V	22 Health Insurance		Nivram Management, Inc.	50.00%	3,521	3,521	10
11	V	6 Scavenger		Nivram Management, Inc.	50.00%	152	152	11
12	V	35 Rental Equipment		Nivram Management, Inc.	50.00%	501	501	12
13	V	25 Auto Expense		Nivram Management, Inc.	50.00%	52	52	13
14	Total		\$ 576,899			\$ 50,094	\$ * (526,805)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	21 Postage	\$	Nivram Management, Inc.	50.00%	\$ 601	\$	601	15
16	V	19 Legal & Accounting		Nivram Management, Inc.	50.00%	6,766		6,766	16
17	V	20 Licenses & Permits		Nivram Management, Inc.	50.00%	42		42	17
18	V	30 Depreciation		Nivram Management, Inc.	50.00%	209		209	18
19	V	21 Data Processing		Nivram Management, Inc.	50.00%	668		668	19
20	V	21 Telepone		Nivram Management, Inc.	50.00%	2,193		2,193	20
21	V	6 Plant Salary		Nivram Management, Inc.	50.00%	37,215		37,215	21
22	V	17 Asst. Administrator		Nivram Management, Inc.	50.00%	55,823		55,823	22
23	V	21 Office Manager		Nivram Management, Inc.	50.00%	22,904		22,904	23
24	V	1 Dietary Supervisor		Nivram Management, Inc.	50.00%	49,500		49,500	24
25	V	17 Administrative		Nivram Management, Inc.	50.00%	165,044		165,044	25
26	V	17 Administrative		Nivram Management, Inc.	50.00%	29,462		29,462	26
27	V	17 Administrative		Nivram Management, Inc.	50.00%	59,899		59,899	27
28	V	21 Cleriel		Nivram Management, Inc.	50.00%	96,476		96,476	28
29	V	34 Rent	1,207,238	Hanry Mermelstein	100.00%			(1,207,238)	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 1,207,238			\$ 526,802	\$ *	(680,436)	39

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

Facility Name & ID Number

Central Nursing

0019364

Report Period Beginning:

01/01/2008

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	Henry Mermelstein	Administrator	Administrative	0.00	137,456	22	54.56	Salary	\$ 165,044	17-8	1
2	Louise Mermelstein	Dietary Supervisor	Support	0.00	49,500	20	50.00	Salary	49,500	1-8	2
3	Marvin Mermelstein	Plant Supervisor	Support	50.00	94,785	5	28.19	Salary	37,215	6-8	3
4	Doreen Mermelsein	Office Manager	Administrative	0.00	90,996	8	20.11	Salary	22,904	21-8	4
5											5
6	Marvin Mermelstein	Asst. Administrator	Administrative	See Above	142,177	8	28.19	Salary	55,823	17-8	6
7	Joseph Memelstein	Owner	Administrative	50.00	75,038	3	28.19	Salary	29,462	17-8	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 359,948		13

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

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

Facility Name & ID Number Central Nursing# 0019364 Report Period Beginning: 01/01/2008 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 Nivram Management, Inc.
 Street Address 6500 N. Hamlin Avenue
 City / State / Zip Code Lincolnwood, IL 60712
 Phone Number (847) 679-7484
 Fax Number (847) 679-7494

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Delivery Expense	Resident Beds	869	4	\$ 2,205	\$ 245	\$ 622	1
2	21	Office Expense	Resident Beds	869	4	4,269	245	1,204	2
3	20	Dues & Subscriptions	Resident Beds	869	4	460	245	130	3
4	21	Franchise Tax	Resident Beds	869	4	100	245	28	4
5	22	Payroll Taxes	Resident Beds	869	4	131,039	245	36,944	5
6	5	Utilities	Resident Beds	869	4	15,594	245	4,396	6
7	27	Insurance	Resident Beds	869	4	1,745	245	492	7
8	6	Repairs & Maintenance	Resident Beds	869	4	7,278	245	2,052	8
9	22	Health Insurance	Resident Beds	869	4	12,490	245	3,521	9
10	6	Scavenger	Resident Beds	869	4	538	245	152	10
11	35	Rental Equipment	Resident Beds	869	4	1,777	245	501	11
12	25	Auto Expense	Resident Beds	869	4	183	245	52	12
13	21	Postage	Resident Beds	869	4	2,133	245	601	13
14	19	Legal & Accounting	Resident Beds	869	4	24,000	245	6,766	14
15	20	Licenses & Permits	Resident Beds	869	4	150	245	42	15
16	30	Depreciation	Resident Beds	869	4	743	245	209	16
17	21	Data Processing	Resident Beds	869	4	2,369	245	668	17
18	21	Telephone	Resident Beds	869	4	7,780	245	2,193	18
19	6	Plant Salary	Direct Cost	1	1	37,215	1	37,215	19
20	17	Asst. Administrator	Direct Cost	1	1	55,823	1	55,823	20
21	21	Office Manager	Direct Cost	1	1	22,904	1	22,904	21
22	1	Dietary Supervisor	Direct Cost	1	1	49,500	1	49,500	22
23	17	Administrative	Direct Cost	1	1	254,405	1	254,405	23
24	21	Clerical	Direct Cost	1	1	96,476	1	96,476	24
25	TOTALS					\$ 731,176	\$	\$ 576,896	25

Facility Name & ID Number

Central Nursing

0019364

Report Period Beginning:

01/01/2008

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																				
2																				
3																				
4																				
5																				
Working Capital																				
6																				
7																				
8																				
9	TOTAL Facility Related																			
B. Non-Facility Related*																				
10																				
11																				
12																				
13																				
14	TOTAL Non-Facility Related																			
15	TOTALS (line 9+line14)																			

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

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

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

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 Central Nursing COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0019364

CONTACT PERSON REGARDING THIS REPORT Sanford B. Alper

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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>13-29-431-013-0000</u>	<u>2450 N. Central Avenue</u>	\$ <u>15,153.84</u>	\$ <u>15,153.84</u>
2. <u>13-29-431-014-0000</u>	<u>2450 N. Central Avenue</u>	\$ <u>36,677.93</u>	\$ <u>36,677.93</u>
3. <u>13-29-431-015-0000</u>	<u>2450 N. Central Avenue</u>	\$ <u>36,729.47</u>	\$ <u>36,729.47</u>
4. <u>13-29-431-016-0000</u>	<u>2450 N. Central Avenue</u>	\$ <u>36,905.86</u>	\$ <u>36,905.86</u>
5. <u>13-29-431-017-0000</u>	<u>2450 N. Central Avenue</u>	\$ <u>36,689.32</u>	\$ <u>36,689.32</u>
6. <u>13-29-431-018-0000</u>	<u>2450 N. Central Avenue</u>	\$ <u>36,677.93</u>	\$ <u>36,677.93</u>
7. <u>13-29-431-019-0000</u>	<u>2450 N. Central Avenue</u>	\$ <u>36,472.58</u>	\$ <u>36,472.58</u>
8. <u>13-29-431-020-0000</u>	<u>2450 N. Central Avenue</u>	\$ <u>29,141.29</u>	\$ <u>29,141.29</u>
9. <u>13-29-431-021-0000</u>	<u>2450 N. Central Avenue</u>	\$ <u>1,843.78</u>	\$ <u>1,843.78</u>
10. <u>13-29-431-022-0000</u>	<u>2450 N. Central Avenue</u>	\$ <u>1,918.35</u>	\$ <u>1,918.35</u>
	TOTALS	\$ <u>268,210.35</u>	\$ <u>268,210.35</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 Central Nursing

0019364

Report Period Beginning:

01/01/2008 Ending:

12/31/08

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 67,185 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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

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

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

XI. OWNERSHIP COSTS:

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

Facility Name & ID Number Central Nursing

0019364

Report Period Beginning:

01/01/2008 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		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	245		1973	1973	\$ 1,729,156	\$	30	\$	\$	\$ 1,729,156	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Spinkler System		1976		8,246		20			8,246	9
10	Hot Water Heater		1983		2,156		10			2,156	10
11	Light Fixtures		1984		14,684		10			14,684	11
12	Roof		1984		20,000		20			20,000	12
13	Heating & Air Conditioning		1983		2,924		20			2,924	13
14	Painting & Decorating		1983		7,863		8			7,863	14
15	Doorways		1986		1,840		15			1,840	15
16	Elevator Upgrade		1986		1,080		20			1,080	16
17	Wall Corner Guard		1987		1,531	48	10		(48)	1,531	17
18	Resurface Parking Lot		1987		6,900	219	15		(219)	6,900	18
19	Additions		1988		1,200	38	20	60	22	1,183	19
20	Heater Foundation		1989		1,000	31	20	50	19	935	20
21	Roof		1990		7,916	251	20	396	145	6,779	21
22	Roof		1990		2,199	70	8		(70)	2,199	22
23	Various Improvements		1990		1,850		8			1,850	23
24	Cibicle Curtains		1992		11,273	358	10		(358)	11,273	24
25	HVACC Curtains		1993		8,907		10			8,907	25
26	Draperies		1993		2,700		10			2,700	26
27	Tiling		1995		6,600	170	10		(170)	6,600	27
28	Leasehold Improvements		1995		15,914		10			15,914	28
29	Generator		1996		17,527	450	10	1,753	1,303	20,046	29
30	Roof		1996		4,800	124	10	480	356	5,489	30
31	Doorways		1997		2,465	63	10	247	184	2,577	31
32	Wiring for Emergency System		1997		5,000	128	10	500	372	5,218	32
33	Phone System		1997		8,238		10	824	824	8,223	33
34	Architecture		1998		6,000	154	10	600	446	5,661	34
35	Boiler, A/C, Ductwork		1998		16,664		10	1,666	1,666	15,650	35
36											36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number Central Nursing

0019364

Report Period Beginning:

01/01/2008 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	Roofing	1998	\$ 54,000	\$ 1,384	10	\$ 5,400	\$ 4,016	\$ 50,955	37
38	Parking Lot Improvements	1998	8,000		10	800	800	7,733	38
39	Elevator Improvements	1998	4,450	117	10	445	328	3,684	39
40	HVAC Improvements	1998	2,820	72	10	282	210	2,379	40
41	Fire Alarm System Doors	1999	107,450	2,756	10	10,750	7,994	90,685	41
42	Extended Walls Ththrough Ceiling	1999	3,000	77	10	300	223	2,531	42
43	Elevator Improvements	1999	2,650	68	10	265	197	2,240	43
44	HVAC Improvements	1999	20,388	523	10	2,039	1,516	17,195	44
45	Landscape Work	1999	4,100	105	10	410	305	3,048	45
46	Elevator Improvements	2000	89,750	2,302	10	8,975	6,673	57,762	46
47	HVAC Improvements	2000	23,639	606	10	2,364	1,758	15,214	47
48	Telephone System	2000	7,500	192	10	750	558	5,157	48
49	Air Conditioning System	2001	4,000	102	10	400	298	2,310	49
50	Air Conditioning System	2001	10,800	277	10	1,080	803	5,286	50
51	Air Conditioning System	2001	2,500	64	10	250	186	1,050	51
52	Air Conditioning System	2003	5,800	74	10	580	506	4,310	52
53	Door	2004	1,742	45	10	174	129	441	53
54	Nurse Call System	2005	11,000	282	10	1,100	818	2,717	54
55	Dual Patient Station	2005	1,485	38	10	149	111	368	55
56	Wiring-Elevator Recall Relays	2005	480	13	10	48	35	110	56
57	Air Cleaning Equipment	2005	2,936	75	10	294	219	701	57
58	Condenser	2005	1,780	46	10	178	132	424	58
59	Fan Coil Unit	2005	2,832	72	10	283	211	651	59
60	Hot Water Heater	2006	3,100	207	10	310	103	741	60
61	Water Heater	2006	6,000	400	10	600	200	1,233	61
62	A/C Compressor	2006	8,190	546	10	819	273	1,866	62
63	Emergency Light Connected to Fire Alarm	2006	595	400	10	59	(341)	128	63
64	Boiler Combustion Tiles	2007	1,250	84	10	63	(21)	126	64
65	Boilers	2007	12,000	800	10	600	(200)	1,200	65
66	Water Heater	2007	6,000	400	10	300	(100)	600	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,326,870	\$ 14,231		\$ 46,643	\$ 32,412	\$ 2,200,429	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 75,141	\$ 9,917	\$ 7,514	\$ (2,403)	10	\$ 66,089	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	352,570				10	352,570	73
74	Nivram Management Depr		209	9,513	9,304			74
75	TOTALS	\$ 427,711	\$ 10,126	\$ 17,027	\$ 6,901		\$ 418,659	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Storage	Storage Trailer	1986	\$ 900	\$	\$	\$	10	\$ 900	76
77	Administrative	1999 Oldsmobile	1999	22,218				6	22,218	77
78										78
79										79
80	TOTALS			\$ 23,118	\$	\$	\$		\$ 23,118	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,936,676	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 24,357	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 63,670	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 39,313	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,642,206	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Henry Mermelstein

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>1,207,238</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ <u>1,207,238</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: \$ 2,673 Description: Ice Maker - \$900; Copy Machine - \$1,272; Copy Machine (related party) - \$501

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning 01/01/2008

Ending 12/31/2008

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

Fiscal Year Ending Annual Rent

12. /2009 \$ _____

13. /2010 \$ _____

14. /2011 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$				1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care	39-3	visits	255				17	255	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				240,000		240,000	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Rental</u>						7,805		7,805	12
13	Other (specify): _____									13
14	TOTAL			\$ 255		\$	\$ 247,805	17	\$ 248,060	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Central Nursing

0019364

Report Period Beginning: 01/01/2008

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	\$ 477,746	\$ 477,746	1
2	Cash-Patient Deposits	90,729	90,729	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,519,970	2,519,970	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	62,435	62,435	6
7	Other Prepaid Expenses	1,794	1,794	7
8	Accounts Receivable (owners or related parties)	4,211,104	4,211,104	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 7,363,778	\$ 7,363,778	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		158,977	13
14	Buildings, at Historical Cost		1,729,156	14
15	Leasehold Improvements, at Historical Cost	511,983	553,228	15
16	Equipment, at Historical Cost	309,706	547,064	16
17	Accumulated Depreciation (book methods)	(448,418)	(2,314,436)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Deposits</u>	500,100	500,100	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 873,371	\$ 1,174,089	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,237,149	\$ 8,537,867	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 898,792	\$ 898,792	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	91,138	91,138	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	19,102	19,102	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	276,000	276,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	53,120	53,120	35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	1,317,277	1,317,277	36
37	<u>Due to IDPA</u>	24,115	24,115	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,679,544	\$ 2,679,544	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,679,544	\$ 2,679,544	46
47	TOTAL EQUITY(page 18, line 24)	\$ 5,557,605	\$ 5,858,323	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,237,149	\$ 8,537,867	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,537,220	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,537,220	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	3,520,385	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(2,500,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,020,385	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)	\$ 5,557,605	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached. Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 9,698,768	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,698,768	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,621	6
7	Oxygen	74,843	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 76,464	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,081	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 5,081	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	62,592	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 62,592	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Vending Income</u>	2,063	28
28a	<u>Miscellaneous Income</u>	9,159	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 11,222	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,854,127	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	921,576	31
32	Health Care	1,973,077	32
33	General Administration	1,516,427	33
	B. Capital Expense		
34	Ownership	1,486,080	34
	C. Ancillary Expense		
35	Special Cost Centers	248,060	35
36	Provider Participation Fee	134,506	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,279,726	40
41	Income before Income Taxes (line 30 minus line 40)**	3,574,401	41
42	Income Taxes	(54,016)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 3,520,385	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

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

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

Facility Name & ID Number Central Nursing

0019364

Report Period Beginning: 01/01/2008

Ending: 12/31/08

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	2,077	2,334	\$ 91,512	\$ 39.21	1
2	Assistant Director of Nursing	1,976	2,225	54,610	24.54	2
3	Registered Nurses	25,827	27,649	709,920	25.68	3
4	Licensed Practical Nurses	6,042	6,582	119,956	18.22	4
5	CNAs & Orderlies	52,591	57,561	562,017	9.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,996	7,496	69,188	9.23	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	3,185	3,449	50,568	14.66	13
14	Head Cook	2,148	2,356	26,725	11.34	14
15	Cook Helpers/Assistants	8,835	9,946	84,849	8.53	15
16	Dishwashers					16
17	Maintenance Workers	1,984	2,231	24,302	10.89	17
18	Housekeepers	15,550	17,075	200,964	11.77	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,930	16,978	261,489	15.40	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)	143,141	155,882	\$ 2,256,100 *	\$ 14.47	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 17,220	1-3	35
36	Medical Director	O			36
37	Medical Records Consultant	N			37
38	Nurse Consultant	T			38
39	Pharmacist Consultant	H			39
40	Physical Therapy Consultant	L			40
41	Occupational Therapy Consultant	Y			41
42	Respiratory Therapy Consultant		7,446	10a-3	42
43	Speech Therapy Consultant	F	66	10a-3	43
44	Activity Consultant	E			44
45	Social Service Consultant	E	3,588	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 28,320		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	10,911	\$ 267,317	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	10,911	\$ 267,317		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
			\$	Workers' Compensation Insurance	\$ 51,299	IDPH License Fee	\$		
				Unemployment Compensation Insurance	21,765	Advertising: Employee Recruitment	4,165		
				FICA Taxes	180,172	Health Care Worker Background Check			
				Employee Health Insurance	127,949	(Indicate # of checks performed <u>75</u>)	525		
				Employee Meals	29,936	Patient Background Checks	138		
				Illinois Municipal Retirement Fund (IMRF)*		Yellow Page Advertising	4,148		
				Union Pension	16,119	IL Council on Long Term Care	18,387		
				Other Employee Benefits	3,576	IL Association of Health Care Facilities	2,940		
				Chicago Head Tax	3,760	See Attached Schedule	1,423		
				Allocation from Management	40,465	Allocation from Management	172		
						Less: Public Relations Expense	()		
						Non-allowable advertising	()		
						Yellow page advertising	(4,148)		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$	TOTAL (agree to Schedule V, line 22, col.8)		\$ 28,992			
			\$ 576,899						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 576,899	E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**			
C. Professional Services			Amount	Description	Line #	Amount	Description	Amount	
Vendor/Payee	Type								
Kessler, Orlean, Silver	Accounting		\$ 17,700				Out-of-State Travel	\$	
Health Data Systems	Computer Support		9,353						
ADP	Payroll Service		2,703						
Accu-Med Services, Inc.	Computer Support		6,376				In-State Travel		
Medifax-EDI, LLC	Data Processing		1,344						
Neal Gerber & Eisenberg	Legal		5,572						
Mazher Shan-Khan	Legal		1,500						
Richard Peelo	Healthcare Consultant		4,200				Seminar Expense	2,425	
Anthony's Mobile Fingerprinting	Fingerprinting Services		105						
Personnel Planners, Inc.	Unemployment Consultant		3,014						
Visionshare, Inc.	Access to Medicare System		300				Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 52,167	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 2,425

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Central Nursing

0019364

Report Period Beginning: 01/01/2008

Ending: 12/31/08

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Schedule Attached
- (3) Did the nursing home make political contributions or payments to a political action organization? 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? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 134,506
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 29,936 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? None
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. No
- (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