



Facility Name & ID Number CAPITOL CARE CENTER

# 0045666 Report Period Beginning: 1/1/09 Ending: 12/31/09

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	251	Skilled (SNF)	251	91,615	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	251	TOTALS	251	91,615	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	52,165		11,875	64,040	8
9	SNF/PED					9
10	ICF		3,657		3,657	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	52,165	3,657	11,875	67,697	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.89%

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 10,899

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number **CAPITOL CARE CENTER** # **0045666** Report Period Beginning: **1/1/09** Ending: **12/31/09**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	389,871	46,685	16,223	452,779		452,779		452,779		1
2	Food Purchase		413,766		413,766		413,766	(16)	413,750		2
3	Housekeeping	198,737	57,291		256,028		256,028		256,028		3
4	Laundry	170,953	41,746	4,604	217,303		217,303		217,303		4
5	Heat and Other Utilities			264,985	264,985		264,985	5,648	270,633		5
6	Maintenance	178,954		203,439	382,393		382,393	5,656	388,049		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>938,515</b>	<b>559,488</b>	<b>489,251</b>	<b>1,987,254</b>		<b>1,987,254</b>	<b>11,288</b>	<b>1,998,542</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			28,334	28,334		28,334		28,334		9
10	Nursing and Medical Records	2,715,955	213,623	31,969	2,961,547		2,961,547		2,961,547		10
10a	Therapy	816,996			816,996		816,996		816,996		10a
11	Activities	54,212	11,791	4,298	70,301		70,301		70,301		11
12	Social Services	99,596			99,596		99,596		99,596		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>3,686,759</b>	<b>225,414</b>	<b>64,601</b>	<b>3,976,774</b>		<b>3,976,774</b>		<b>3,976,774</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	117,636		494,400	612,036		612,036	(417,943)	194,093		17
18	Directors Fees										18
19	Professional Services			153,205	153,205		153,205	(25,940)	127,265		19
20	Dues, Fees, Subscriptions & Promotions			76,024	76,024		76,024	(35,971)	40,053		20
21	Clerical & General Office Expenses	376,683	42,013	99,347	518,043		518,043	68,309	586,352		21
22	Employee Benefits & Payroll Taxes			931,964	931,964		931,964		931,964		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,396	8,396		8,396	427	8,823		24
25	Other Admin. Staff Transportation			42,030	42,030		42,030	3,691	45,721		25
26	Insurance-Prop.Liab.Malpractice			243,557	243,557		243,557	(1,690)	241,867		26
27	Other (specify):*							27,886	27,886		27
28	<b>TOTAL General Administration</b>	<b>494,319</b>	<b>42,013</b>	<b>2,048,923</b>	<b>2,585,255</b>		<b>2,585,255</b>	<b>(381,231)</b>	<b>2,204,024</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>5,119,593</b>	<b>826,915</b>	<b>2,602,775</b>	<b>8,549,283</b>		<b>8,549,283</b>	<b>(369,943)</b>	<b>8,179,340</b>		<b>29</b>

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

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

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			183,230	183,230		183,230	(78,650)	104,580			30
31	Amortization of Pre-Op. & Org.							263	263			31
32	Interest			57,425	57,425		57,425	(3,298)	54,127			32
33	Real Estate Taxes			77,417	77,417		77,417	2,434	79,851			33
34	Rent-Facility & Grounds			944,780	944,780		944,780		944,780			34
35	Rent-Equipment & Vehicles			155,137	155,137		155,137	870	156,007			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,417,989	1,417,989		1,417,989	(78,381)	1,339,608			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			492,535	492,535		492,535		492,535			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			137,423	137,423		137,423		137,423			42
43	Other (specify):*							(25,699)	(25,699)			43
44	<b>TOTAL Special Cost Centers</b>			629,958	629,958		629,958	(25,699)	604,259			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,119,593	826,915	4,650,722	10,597,230		10,597,230	(474,023)	10,123,207			45

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

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

# **0045666**

Report Period Beginning:

1/1/09

Ending:

12/31/09

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(82,010)	30		9
10	Interest and Other Investment Income	(7,004)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(16)	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	(12,651)	21		18
19	Entertainment				19
20	Contributions	(7,170)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(35,068)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(29,312)	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	(66,520)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (239,751)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
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)	(234,272)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (234,272)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (474,023)		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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

**BHF USE ONLY**

48		49		50		51		52	
----	--	----	--	----	--	----	--	----	--

CAPITOL CARE CENTER

ID# 0045666

Report Period Beginning: 1/1/09

Ending: 12/31/09

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	VENDING INCOME	\$ (2,793)	21	1
2	TRANSPORTATION INCOME	(75)	6	2
3	MISCELLANEOUS INCOME	(12,908)	21	3
4	MISCELLANEOUS INCOME-INSURANCE DIV	(2,685)	26	4
5	TAXES-GENERAL	(1,072)	21	5
6	DAMAGE/LOSS/THEFT	(3,766)	21	6
7	IL COUNCIL LTC-COPE	(7,551)	20	7
8	PH ECLIPSE AIRPLANE EXPENSE	(9,971)	25	8
9	MARKETING SALARIES	(21,741)	43	9
10	MARKETING EMPLOYEE BENEFITS	(3,958)	43	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(66,520)		49

## STATE OF ILLINOIS

Summary A

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

1/1/09

Ending:

12/31/09

## 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	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(16)	0	0	0	0	0	0	0	0	0	0	(16)	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	5,648	0	0	0	0	0	0	0	0	5,648	5
6	Maintenance	(75)	0	5,731	0	0	0	0	0	0	0	0	5,656	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(91)</b>	<b>0</b>	<b>11,379</b>	<b>0</b>	<b>11,288</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	(417,943)	0	0	0	0	0	0	0	0	(417,943)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(35,068)	0	9,128	0	0	0	0	0	0	0	0	(25,940)	19
20	Fees, Subscriptions & Promotions	(36,863)	0	892	0	0	0	0	0	0	0	0	(35,971)	20
21	Clerical & General Office Expenses	(40,360)	0	108,669	0	0	0	0	0	0	0	0	68,309	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	427	0	0	0	0	0	0	0	0	427	24
25	Other Admin. Staff Transportation	(9,971)	0	13,662	0	0	0	0	0	0	0	0	3,691	25
26	Insurance-Prop.Liab.Malpractice	(2,685)	0	995	0	0	0	0	0	0	0	0	(1,690)	26
27	Other (specify):*	0	0	27,886	0	0	0	0	0	0	0	0	27,886	27
28	<b>TOTAL General Administration</b>	<b>(124,947)</b>	<b>0</b>	<b>(256,284)</b>	<b>0</b>	<b>(381,231)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(125,038)</b>	<b>0</b>	<b>(244,905)</b>	<b>0</b>	<b>(369,943)</b>	<b>29</b>							

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number CAPITOL CARE CENTER# 0045666

Report Period Beginning:

1/1/09

Ending:

12/31/09

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	(82,010)	0	3,360	0	0	0	0	0	0	0	0	(78,650)	30
31	Amortization of Pre-Op. & Org.	0	0	263	0	0	0	0	0	0	0	0	263	31
32	Interest	(7,004)	0	3,706	0	0	0	0	0	0	0	0	(3,298)	32
33	Real Estate Taxes	0	0	2,434	0	0	0	0	0	0	0	0	2,434	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	870	0	0	0	0	0	0	0	0	870	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(89,014)</b>	<b>0</b>	<b>10,633</b>	<b>0</b>	<b>(78,381)</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(25,699)	0	0	0	0	0	0	0	0	0	0	(25,699)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(25,699)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(25,699)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(239,751)	0	(234,272)	0	0	0	0	0	0	0	0	(474,023)	45

Facility Name & ID Number CAPITOL CARE CENTER

# 0045666

Report Period Beginning:

1/1/09

Ending:

12/31/09

**VII. RELATED PARTIES**

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	<b>Total</b>		\$			\$	\$ *	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	17 Home Office	\$ 494,400	Platinum Health Care, LLC	100.00%	\$	\$ (494,400)
16	V	5 Utilities		Platinum Health Care, LLC		5,648	5,648
17	V	6 Repairs & Maintenance		Platinum Health Care, LLC		5,731	5,731
18	V	17 Administrative Salary		Platinum Health Care, LLC		76,457	76,457
19	V	19 Professional Fees		Platinum Health Care, LLC		9,128	9,128
20	V	20 Fees, Subscriptions		Platinum Health Care, LLC		892	892
21	V	21 Clerical Salaries		Platinum Health Care, LLC		94,895	94,895
22	V	21 Office Expenses		Platinum Health Care, LLC		13,774	13,774
23	V	24 Education & Seminars		Platinum Health Care, LLC		427	427
24	V	25 Travel		Platinum Health Care, LLC		13,662	13,662
25	V	26 Insurance		Platinum Health Care, LLC		995	995
26	V	27 Employee Benefits		Platinum Health Care, LLC		27,886	27,886
27	V	30 Depreciation		Platinum Health Care, LLC		1,304	1,304
28	V	35 Equipment Rental		Platinum Health Care, LLC		870	870
29	V	31 Amortization		Platinum Health Care, LLC		263	263
30	V	30 Depreciation		Platinum Health Care, LLC		2,056	2,056
31	V	32 Interest		Platinum Health Care, LLC		3,706	3,706
32	V	33 Real Estate Taxes		Platinum Health Care, LLC		2,434	2,434
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 494,400			\$ 260,128	\$ * (234,272)

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

Facility Name &amp; ID Number

CAPITOL CARE CENTER

#

0045666

Report Period Beginning:

1/1/09

Ending:

12/31/09

## 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	2	6.70	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:

1/1/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Platinum Health Care, LLC

Street Address

7444 Long Avenue

City / State / Zip Code

Skokie, IL 60077

Phone Number

( 847 ) 329-4100

Fax Number

( 847 ) 329-7652

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

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

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	606,157	15	\$ 50,576	\$ 67,697	\$ 5,648	1
2	6	Repairs & Maintenance	Patient Days	606,157	15	51,318	67,697	5,731	2
3	17	Administrative Salary	Patient Days	606,157	15	684,597	684,597	76,457	3
4	19	Professional Fees	Patient Days	606,157	15	81,733	67,697	9,128	4
5	20	Fees, Subscriptions	Patient Days	606,157	15	7,987	67,697	892	5
6	21	Clerical Salaries	Patient Days	606,157	15	849,689	849,689	94,895	6
7	21	Office Expenses	Patient Days	606,157	15	123,336	67,697	13,774	7
8	24	Education & Seminars	Patient Days	606,157	15	3,826	67,697	427	8
9	25	Travel	Patient Days	606,157	15	122,325	67,697	13,662	9
10	26	Insurance	Patient Days	606,157	15	8,909	67,697	995	10
11	27	Employee Benefits	Patient Days	606,157	15	249,694	67,697	27,886	11
12	30	Depreciation	Patient Days	606,157	15	11,677	67,697	1,304	12
13	35	Equipment Rental	Patient Days	606,157	15	7,792	67,697	870	13
14	31	Amortization	Patient Days	606,157	15	2,355	67,697	263	14
15	30	Depreciation	Patient Days	606,157	15	18,405	67,697	2,056	15
16	32	Interest	Patient Days	606,157	15	33,183	67,697	3,706	16
17	33	Real Estate Taxes	Patient Days	606,157	15	21,795	67,697	2,434	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,329,197	\$ 1,534,286	\$ 260,128	25

Facility Name & ID Number

CAPITOL CARE CENTER

# 0045666

Report Period Beginning:

1/1/09

Ending:

12/31/09

**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										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1					\$	\$			\$	1									
2										2									
3										3									
4										4									
5										5									
<b>Working Capital</b>																			
6	<b>First Bank</b>	<b>X</b>	<b>Line of Credit</b>						<b>57,425</b>	<b>6</b>									
7										7									
8										8									
9	<b>TOTAL Facility Related</b>				\$	\$			\$ <b>57,425</b>	<b>9</b>									
<b>B. Non-Facility Related*</b>																			
10	<b>Interest Income</b>								<b>(7,004)</b>	<b>10</b>									
11										11									
12										12									
13	<b>Allocation from Platinum</b>								<b>3,706</b>	<b>13</b>									
14	<b>TOTAL Non-Facility Related</b>				\$	\$			\$ <b>(3,298)</b>	<b>14</b>									
15	<b>TOTALS (line 9+line14)</b>				\$	\$			\$ <b>54,127</b>	<b>15</b>									

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

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

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

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)**

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and

1. Real Estate Tax accrual used on 2008 report.		\$	<b>105,000</b>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<b>77,417</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(27,583)</b>	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>105,000</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>77,417</b>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	<b>98,617</b>	8	
	2005	<b>101,683</b>	9	
	2006	<b>103,293</b>	10	
	2007	<b>100,784</b>	11	
	2008	<b>77,417</b>	12	
				<b>FOR BHF USE ONLY</b>
	13	FROM R. E. TAX STATEMENT FOR 2008	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

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



Facility Name & ID Number CAPITOL CARE CENTER

# 0045666

Report Period Beginning:

1/1/09

Ending:

12/31/09

**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:**

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

**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				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	AWNING		2001	6,950		20	348	348	2,842	9
10	SIGNS & BANNERS		2001	4,354		10	435	435	3,516	10
11	A/C		2002	505		5			505	11
12	A/C		2002	5,263		7	124	124	5,263	12
13	MASONRY RESTORATION		2002	4,098		10	410	410	3,075	13
14	CEILING WORK		2002	1,500		20	75	75	600	14
15	CEILING WORK		2002	1,835		20	92	92	720	15
16	DOORS		2002	5,665		10	567	567	4,158	16
17	INSTALL GLASS		2002	735		10	74	74	592	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	899	19
20	INSTALL GLASS		2002	550		10	55	55	422	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 A		2002			10				22
23	WATER PUMP REPAIR		2002	1,566		10	157	157	1,125	23
24	WATER HEATER		2002	10,018		12	835	835	6,471	24
25	THERMOSTAT REPAIR		2002	2,287		10	229	229	1,794	25
26	THERMOSTAT REPAIR		2002	825		10	83	83	602	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	2,168	28
29	INSTALL SIGNS		2002	718		10	72	72	576	29
30	ACCESS CONTROL SYSTEM		2002	3,482		10	348	348	2,784	30
31	ACCESS CONTROL SYSTEM		2002	2,646		10	265	265	2,120	31
32	ACCESS CONTROL SYSTEM		2002	588		10	59	59	467	32
33	INSTALL SIGNS		2002	977		10	98	98	767	33
34	SHOWER & GUARD RAILS		2002	535		20	27	27	196	34
35	CALL CORDS		2002	599		20	30	30	230	35
36										36

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

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

See Page 12A, Line 70 for total

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

Report Period Beginning:

**1/1/09**

Ending:

**12/31/09****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	\$ 200	37
38	CURTAIN FOR MAIN DINING ROOM	2003	849		5			849	38
39	REPLACEMENT FOR ZONAIRE	2003	5,565		20	278	278	1,738	39
40	FURNISH & INSTALL NEW CONDENSER	2003	1,521		20	76	76	469	40
41	A/C UNIT	2003	1,100		5			1,100	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	2,844	43
44	ALTERNATE FLOOR FIRE SVCS	2004	3,255		10	326	326	1,874	44
45	OVERHAUL 2 ELEVATORS	2004	40,080		20	2,004	2,004	11,189	45
46	CARPET	2004	9,720		5	1,458	1,458	9,720	46
47	CONSTRUCT NEW OFFICE SPACE (REMOVE \$8,000 PER 200	2005			27.5				47
48	ZONE RESTRICTOR SYSTEM	2005	5,950		27.5	216	216	954	48
49	CARPET	2005	5,754		5	1,151	1,151	4,796	49
50	FIRE SPRINKLERS	2006	7,867		25	315	315	1,181	50
51	REPAIRED DRAIN	2006	2,758		20	138	138	517	51
52	10-A/C FAN BLADES	2006	1,001		10	100	100	367	52
53	SOLAR CONTROL WINDOW	2006	1,442		10	144	144	492	53
54	DRIER & CONDENSER	2006	2,093		10	209	209	697	54
55	DRAIN PIPE & SHOWER VALVE	2006	2,277		20	114	114	380	55
56	DOORS	2006	6,806		20	340	340	1,020	56
57	RED OAK HARDWARE	2007	2,595		20	130	130	368	57
58	PLUMBING REPAIRS AND PART	2007	3,859		20	193	193	531	58
59	REMODEL DOWNSTAIRS LIVING (REMOVE \$4,150 PER 200	2007			15				59
60	REPLACE 4 VALVES AND PIPING	2007	6,011		20	301	301	777	60
61	INSTALL FENCE (REMOVE \$1,800 PER 2008 CAP COST AUD	2007			15				61
62	RPR & RSTR PARKING LOT	2007	5,200		15	347	347	896	62
63	CONCRETE REPLACEMENT	2007	8,333		15	556	556	1,436	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 C	2007			20				65
66	ROOFTOP A/C SYSTEM	2007	7,305		10	731	731	1,766	66
67	AIR HANDLER	2007	6,036		20	302	302	730	67
68	CONCRETE REPLACEMENT	2007	9,127		15	608	608	1,419	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	\$		\$ 15,354	\$ 15,354	\$ 90,197	70

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

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

Report Period Beginning:

**1/1/09**

Ending:

**12/31/09****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	<b>Totals from Page 12A, Carried Forward</b>		\$ 215,647	\$		\$ 15,354	\$ 15,354	\$ 90,197	1
2	PIPE RAIL	2007	8,250		15	550	550	1,238	2
3	CONCRETE REPLACEMENT	2007	11,377		15	758	758	1,642	3
4	ELECTRICAL-OUTSIDE LIGHTS TO CODE	2007	2,328		10	233	233	505	4
5	TVS (MOVE \$5,000 TO MME)	2007			5				5
6	12 BALLASTS (REMOVE \$1,133 PER 2008 CAP COST AUDIT)	2007			10				6
7	2ND FLOOR CONSTRUCTION (REMOVE \$2,000 PER 2008 CA	2007			15				7
8	CONCRETE FRONT WALL,RAMP,PRKG LOT	2007	28,877		15	1,925	1,925	4,010	8
9	120 LIGHTS	2007	3,098		10	310	310	620	9
10	FOOTINGS/CONCRETE RETAINING WALLS	2008	22,994		20	1,150	1,150	1,533	10
11	35' RETAINING WALL (REMOVE \$1,650 FROM \$7,350 PER 20	2008	5,700		15	380	380	462	11
12	REMOVE/REBUILD WALL IN BUSINESS OFFICE	2008	1,500		15	100	100	175	12
13	VINYL FLOORING	2008	56,535		10	5,654	5,654	9,894	13
14	WAINSCOTING IN DINING AREA	2008	30,050		15	2,003	2,003	2,838	14
15	REPLACE 10 CHANDELIERS	2008	3,487		10	349	349	669	15
16	TV RESIDENCE ROOMS	2008	2,000		10	200	200	350	16
17	(6) 23" LCD/(1) 26" LCD & TV MOUNTS	2008	2,791		10	279	279	488	17
18	(14) SHELF WHT WIRE & CLIPS (REMOVE \$1,052 PER 2008	2008			15				18
19	(4)LOCKNETICS DOOR MAGNETS	2008	5,230		10	523	523	872	19
20	(2) LOCKNETICS DOOR MAGNETS	2008	2,446		10	245	245	367	20
21	INDOOR KEYPAD/EXIT SENSOR	2008	3,255		10	326	326	407	21
22	KEYPAD ACCESS, CAMERA & MULTIPLEXER	2008	5,159		10	516	516	559	22
23	TILE - BACK SPLASH (REMOVE \$1,260 PER 2008 CAP COST	2008			10				23
24	(4) 23" LCD TV, (3) MOUNTS	2008	1,552		10	155	155	246	24
25	(34) CUBICLE CURTAINS	2008	2,680		5	536	536	849	25
26	ASCOWITCH AUTO TRANSFER SWITCH	2008	2,623		15	175	175	277	26
27	(6) ZONELINE HEAT/COOL	2008	4,176		15	278	278	440	27
28	(3) CHANDELIERS/(1) FAN (REMOVE \$1,289 PER 2008 CAP C	2008			10				28
29	(3) AC UNITS	2008	7,020		15	468	468	702	29
30	COMPRESSOR 12,000 BTU	2008	2,163		12	180	180	270	30
31	STAINLESS STEEL RECEIVER ON WALK-IN COOLER	2008	1,600		10	160	160	240	31
32	CEMENT/BLACKTOP	2008	2,500		8	313	313	443	32
33		2008	2,195		10	220	220	330	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 437,233	\$		\$ 33,338	\$ 33,338	\$ 120,621	34

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

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

Report Period Beginning:

**1/1/09**

Ending:

**12/31/09****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	<b>Totals from Page 12B, Carried Forward</b>		\$ 437,233	\$		\$ 33,338	\$ 33,338	\$ 120,621	1
2	LIGHT BULBS (REMOVE \$4,914 PER 2009 CAP COST AUDIT	2008	4,914		5	983	983	1,474	2
3	TRANSFER SWITCH	2008	1,354		15	90	90	143	3
4	A/C WORK (REMOVE \$1,762 OF \$5,781 PER 2009 CAP COST A	2008	4,019		15	268	268	493	4
5	LIGHT FIXTURES	2008	1,578		10	158	158	237	5
6	(34) CUBICLE CURTAINS	2008	2,680		5	536	536	804	6
7	ROUTER/PRINTER/INSTALL	2008	5,179		5	1,036	1,036	1,468	7
8	CARPET	2008	432		5	86	86	430	8
9	FRONT RAILING	2008	15,466		15	1,031	1,031	1,375	9
10	(25) FO32T8/SUPER 741 (REMOVE \$3,000 PER 2009 CAP COS	2008			15				10
11	DOOR PARTS--CLOSERS/HINGES	2008	1,590		20	80	80	100	11
12	ROCK FOR PARKING LOT & LANDSCAPING	2008	535		5	107	107	125	12
13	KITCHEN DOOR	2008	1,008		20	50	50	63	13
14	DOORS - 2ND FLOOR	2008	885		15	59	59	69	14
15	42" DOOR W/SIDELITE	2008	4,401		15	293	293	342	15
16	DOOR OPERATOR BY STANLEY	2008	2,805		15	187	187	218	16
17	ARCHITECTURAL SERVICES (REMOVE \$3,600 PER 2009 CA	2008			20				17
18	KEYPAD & RELAY MODULE	2009	2,584		10	237	237	237	18
19	2 DOORS	2009	1,159		15	64	64	64	19
20	50 LIFE SAFETY ACCESS DOOR	2009	5,700		15	317	317	317	20
21	DSL INSTALLATION	2009	5,688		20	190	190	190	21
22	A/C UNITS	2009	7,488		10	499	499	499	22
23	3 UNITS	2009	4,663		10	311	311	311	23
24	WALL REPAIR & REPLACEMENT	2009	10,575		20	308	308	308	24
25	10 UNITS	2009	15,544		10	907	907	907	25
26	ASPHALT DRIVE & PARKING LOT	2009	41,200		8	3,004	3,004	3,004	26
27	FLOORING	2009	1,405		10	59	59	59	27
28	NEW SIGNS & AWNING PANEL	2009	4,997		10	167	167	167	28
29	3 CLEAR GLASS IN	2009	1,340		20	22	22	22	29
30	CONCRETE HANDICAPPED	2009	6,000		15	133	133	133	30
31	REPAIR STAIRWELL DOOR	2009	2,689		20	34	34	34	31
32	WHEELCHAIR RAMP & CONCRETE	2009	1,850		15	21	21	21	32
33	MASONRY	2009	1,350		15	15	15	15	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 598,311	\$		\$ 44,590	\$ 44,590	\$ 134,250	34

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

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

# **0045666**

Report Period Beginning:

1/1/09

Ending:

12/31/09

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ 598,311	\$		\$ 44,590	\$ 44,590	\$ 134,250	1
2	ELEVATOR WORK	2009	14,500		20	121	121	121	2
3	NEW ALMINUM DOOR	2009	2,975		20	12	12	12	3
4	2 SMOKE DETECTORS & DOOR	2009	2,310		10	19	19	19	4
5	FIRE SPRINLKER SYSTEM	2009	2,816		25	9	9	9	5
6	ELECTRICAL WORK	2009	3,797		20				6
7	LARGE ARBOR VIDAE	2009	1,063		15	53	53	53	7
8	TINTS FOR KITCHEN	2009	767		20				8
9				83,974			(83,974)		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	Allocation for Platinum Health Care (Bldg & Impr)			1,347		1,347			29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 626,539	\$ 85,321		\$ 46,151	\$ (39,170)	\$ 134,464	34

\*\*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	\$ 544,525	\$ 50,689	\$ 51,543	\$ 854		\$ 278,924	71
72	Current Year Purchases	80,945	48,567	4,873	(43,694)		4,873	72
73	Fully Depreciated Assets							73
74	Allocation from PHC		2,013	2,013				74
75	TOTALS	\$ 625,470	\$ 101,269	\$ 58,429	\$ (42,840)		\$ 283,797	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)	\$ 1,252,009	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 186,590	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 104,580	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (82,010)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 418,261	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

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

If NO, see instructions.

YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ 944,780			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ 944,780			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: \$ 128,435 Description: See Attached Schedule

(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	See Attached Schedule		\$	\$ 26,702	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 26,702	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_/2010 \$ \_\_\_\_\_

13. \_\_\_\_\_/2011 \$ \_\_\_\_\_

14. \_\_\_\_\_/2012 \$ \_\_\_\_\_

\* 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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$			\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							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				456,210		456,210	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <b>Lab &amp; X-ray</b>	39-02					36,325		36,325	13
14	<b>TOTAL</b>			\$		\$	492,535		\$ 492,535	14

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

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

# **0045666**

Report Period Beginning: **1/1/09**

Ending: **12/31/09**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/09** (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ (31,216)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	3,655,548		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	315,503		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <b>Due from Medicare</b>	214,258		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 4,154,093	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	684,498		15
16	Equipment, at Historical Cost	609,681		16
17	Accumulated Depreciation (book methods)	(750,111)		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):	485,532		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,029,600	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,183,693	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 2,400,096	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	301,244		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	105,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<b>Accrued Expenses</b>	168,566		36
37	<b>Due Others &amp; Adv Billing</b>	627,629		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 3,602,535	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	910,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 910,000	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 4,512,535	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 671,158	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 5,183,693	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>560,219</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>ROUNDING</b>	<b>(3)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>560,216</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>110,942</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>110,942</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>671,158</b>	<b>24</b> *

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

Facility Name & ID Number **CAPITOL CARE CENTER**# **0045666**Report Period Beginning: **1/1/09**Ending: **12/31/09**

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 7,988,667	1
2	Discounts and Allowances for all Levels	(520,823)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 7,467,844	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,680,495	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 2,680,495	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	507,848	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	26,265	19
20	Radiology and X-Ray	255	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 534,368	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	7,004	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 7,004	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>TRANSPORTATION, VENDING, MISC INCOME</b>	18,461	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 18,461	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 10,708,172	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,987,254	31
32	Health Care	3,976,774	32
33	General Administration	2,585,255	33
<b>B. Capital Expense</b>			
34	Ownership	1,417,989	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	492,535	35
36	Provider Participation Fee	137,423	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 10,597,230	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	110,942	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 110,942	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:

**1/1/09**

Ending:

**12/31/09**

**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	1,838	1,988	\$ 87,669	\$ 44.10	1
2	Assistant Director of Nursing	10,380	11,217	261,068	23.27	2
3	Registered Nurses	12,334	13,098	293,325	22.39	3
4	Licensed Practical Nurses	36,816	40,758	776,099	19.04	4
5	CNAs & Orderlies	112,216	116,573	1,264,473	10.85	5
6	CNA Trainees					6
7	Licensed Therapist	6,585	7,170	404,816	56.46	7
8	Rehab/Therapy Aides	16,540	18,436	412,180	22.36	8
9	Activity Director	1,417	1,538	22,040	14.33	9
10	Activity Assistants	4,279	4,606	32,172	6.98	10
11	Social Service Workers	5,685	5,962	99,596	16.71	11
12	Dietician					12
13	Food Service Supervisor	1,808	1,987	38,711	19.48	13
14	Head Cook					14
15	Cook Helpers/Assistants	35,022	36,952	351,160	9.50	15
16	Dishwashers					16
17	Maintenance Workers	12,666	13,944	178,954	12.83	17
18	Housekeepers	20,544	21,547	198,737	9.22	18
19	Laundry	14,425	15,737	170,953	10.86	19
20	Administrator	1,875	2,085	117,636	56.42	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	21,934	23,840	376,683	15.80	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	1,827	1,961	33,321	16.99	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	318,191	339,399	\$ 5,119,593 *	\$ 15.08	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	288	\$ 16,223	01-03	35
36	Medical Director	Monthly	28,334	09-03	36
37	Medical Records Consultant	Quarterly	1,760	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant		12,209	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				45
46	Other(specify) <u>Psychiatric Cons</u>		18,000	10-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)	288	\$ 76,526		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**

Report Period Beginning: 1/1/09

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function				Description	Amount	Description	Amount	
CYNTHIA SCHAAF	Administrator		\$ 117,636	Workers' Compensation Insurance	\$ 187,168	IDPH License Fee	\$		
				Unemployment Compensation Insurance	135,584	Advertising: Employee Recruitment		16,036	
				FICA Taxes	386,263	Health Care Worker Background Check		1,797	
				Employee Health Insurance	205,460	(Indicate # of checks performed 147 )			
				Employee Meals		Patient Background Checks		165	
				Illinois Municipal Retirement Fund (IMRF)*		ADVERTISING & MARKETING		29,312	
				401K	4,260	DUES & SUBSCRIPTIONS		16,685	
				EMPLOYEE BENEFITS-OTHER	12,424	LICENSES		4,643	
				EMPLOYEE PHYSICAL EXAM	805				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 117,636			ALLOCATION FROM PLATINUM		892	
B. Administrative - Other						Less: Public Relations Expense	(		
Description			Amount			Non-allowable advertising		(29,312)	
			\$			Yellow page advertising	(		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$		TOTAL (agree to Schedule V, line 22, col.8)	\$ 931,964		TOTAL (agree to Sch. V, line 20, col. 8)	\$ 40,053
C. Professional Services					E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
SEE ATTACHED SCHEDULE			\$ 153,205			\$	Out-of-State Travel	\$	
							In-State Travel		
							Seminar Expense	8,396	
							ALLOCATION FROM PLATINUM	427	
							Entertainment Expense	(	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 153,205	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 8,823	

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name & ID Number CAPITOL CARE CENTER# 0045666

Report Period Beginning:

1/1/09

Ending:

12/31/09**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 \$18,599
- (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. \$ 967 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. \$ 137,423  
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?  
**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: \_\_\_\_\_
- (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.