FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0045666

Facility Name: CAPITOL CARE CENTER

Address: 555 WEST CARPENTER (Number) SPRINGFIELD (City) 62702 (Zip Code)

County: SANGAMON

Telephone Number: (217) 525-1880 **Fax #** (217) 525-7762

HFS ID Number:

Date of Initial License for Current Owners: 10/01/01

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: DARRYL BUEKER **Telephone Number:** (417) 865-8701
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/10 to 12/31/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer

(Signed) (Date)
(Print Name and Title) DARRYL BUEKER, CPA, PARTNER
(Firm Name & Address) BKD, LLP, P. O. BOX 1190, SPRINGFIELD, MO 65801-1190
(Telephone) (417) 865-8701 Fax # (417) 865-0682

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 1/1/10 Ending: 12/31/10

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	48,486		12,879	61,365	8
9	SNF/PED					9
10	ICF		4,124		4,124	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	48,486	4,124	12,879	65,489	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.48%

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 [X]

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

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 [X] Date 10/01/01 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 251 and days of care provided 11,285

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	408,727	50,192	16,081	475,000		475,000		475,000			1
2	Food Purchase		408,141		408,141		408,141	(25)	408,116			2
3	Housekeeping	252,191	42,576		294,767		294,767		294,767			3
4	Laundry	140,495	40,258		180,753		180,753		180,753			4
5	Heat and Other Utilities			325,164	325,164		325,164	5,867	331,031			5
6	Maintenance	176,036		190,239	366,275		366,275	495	366,770			6
7	Other (specify):*											7
8	TOTAL General Services	977,449	541,167	531,484	2,050,100		2,050,100	6,337	2,056,437			8
	B. Health Care and Programs											
9	Medical Director			30,000	30,000		30,000		30,000			9
10	Nursing and Medical Records	2,959,443	199,614	35,355	3,194,412		3,194,412		3,194,412			10
10a	Therapy	716,955		108,564	825,519		825,519		825,519			10a
11	Activities	64,318	12,400	1,203	77,921		77,921		77,921			11
12	Social Services	107,075		465	107,540		107,540		107,540			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,847,791	212,014	175,587	4,235,392		4,235,392		4,235,392			16
	C. General Administration											
17	Administrative	143,423		494,400	637,823		637,823	(471,995)	165,828			17
18	Directors Fees											18
19	Professional Services			219,092	219,092		219,092	(4,673)	214,419			19
20	Dues, Fees, Subscriptions & Promotions			94,700	94,700		94,700	(58,648)	36,052			20
21	Clerical & General Office Expenses	289,429	58,641	99,435	447,505		447,505	108,121	555,626			21
22	Employee Benefits & Payroll Taxes			852,114	852,114		852,114		852,114			22
23	Inservice Training & Education											23
24	Travel and Seminar			18,667	18,667		18,667	519	19,186			24
25	Other Admin. Staff Transportation			50,956	50,956		50,956	(12,963)	37,993			25
26	Insurance-Prop.Liab.Malpractice			247,883	247,883		247,883	757	248,640			26
27	Other (specify):*							16,623	16,623			27
28	TOTAL General Administration	432,852	58,641	2,077,247	2,568,740		2,568,740	(422,259)	2,146,481			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,258,092	811,822	2,784,318	8,854,232		8,854,232	(415,922)	8,438,310			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number CAPITOL CARE CENTER #0045666 Report Period Beginning: 1/1/10 Ending: 12/31/10

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			157,833	157,833		157,833	(35,976)	121,857			30
31	Amortization of Pre-Op. & Org.							412	412			31
32	Interest			41,041	41,041		41,041	(14,278)	26,763			32
33	Real Estate Taxes			35,429	35,429		35,429	1,971	37,400			33
34	Rent-Facility & Grounds			967,683	967,683		967,683		967,683			34
35	Rent-Equipment & Vehicles			154,500	154,500		154,500	307	154,807			35
36	Other (specify):*											36
37	TOTAL Ownership			1,356,486	1,356,486		1,356,486	(47,564)	1,308,922			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			508,222	508,222		508,222		508,222			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):*							(63,038)	(63,038)			43
44	TOTAL Special Cost Centers			645,645	645,645		645,645	(63,038)	582,607			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,258,092	811,822	4,786,449	10,856,363		10,856,363	(526,524)	10,329,839			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: 1/1/10 Ending: 12/31/10

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 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	(39,628)	30		9
10	Interest and Other Investment Income	(17,784)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(25)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(5,850)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(9,407)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(51,609)	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	(114,461)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (238,764)		$	30

BHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 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)	(287,760)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (287,760)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (526,524)		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 Yes	2 No	3 Amount	4 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

CAPITOL CARE CENTER

ID# 0045666

Report Period Beginning: 1/1/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	IL COUNCIL LTC - COPE	$ (8,729)	20	1
2	TRANSPORTATION INCOME	(5,009)	6	2
3	MISCELLANEOUS INCOME	(2,844)	21	3
4	VENDING INCOME	(3,513)	21	4
5	TAXES-GENERAL	(8,346)	21	5
6	DAMAGE/LOSS/THEFT	(2,604)	21	6
7	MARKETING SALARIES	(54,247)	43	7
8	MARKETING EMPLOYEE BENEFITS	(8,791)	43	8
9	TRAVEL EXPENSE-AIRPLANE	(20,378)	25	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**	(114,461)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(25)	0	0	0	0	0	0	0	0	0	0	(25)	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	5,867	0	0	0	0	0	0	0	0	5,867	5
6	Maintenance	(5,009)	0	5,504	0	0	0	0	0	0	0	0	495	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,034)	0	11,371	0	0	0	0	0	0	0	0	6,337	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(471,995)	0	0	0	0	0	0	0	0	(471,995)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(9,407)	(4,367)	9,101	0	0	0	0	0	0	0	0	(4,673)	19
20	Fees, Subscriptions & Promotions	(60,338)	0	1,690	0	0	0	0	0	0	0	0	(58,648)	20
21	Clerical & General Office Expenses	(23,157)	0	131,278	0	0	0	0	0	0	0	0	108,121	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	519	0	0	0	0	0	0	0	0	519	24
25	Other Admin. Staff Transportation	(20,378)	0	7,415	0	0	0	0	0	0	0	0	(12,963)	25
26	Insurance-Prop.Liab.Malpractice	0	0	757	0	0	0	0	0	0	0	0	757	26
27	Other (specify):*	0	0	16,623	0	0	0	0	0	0	0	0	16,623	27
28	**TOTAL General Administration**	(113,280)	(4,367)	(304,612)	0	0	0	0	0	0	0	0	(422,259)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(118,314)	(4,367)	(293,241)	0	0	0	0	0	0	0	0	(415,922)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(39,628)	0	3,652	0	0	0	0	0	0	0	0	(35,976)	30
31	Amortization of Pre-Op. & Org.	0	0	412	0	0	0	0	0	0	0	0	412	31
32	Interest	(17,784)	0	3,506	0	0	0	0	0	0	0	0	(14,278)	32
33	Real Estate Taxes	0	0	1,971	0	0	0	0	0	0	0	0	1,971	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	307	0	0	0	0	0	0	0	0	307	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(57,412)	0	9,848	0	0	0	0	0	0	0	0	(47,564)	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):*	(63,038)	0	0	0	0	0	0	0	0	0	0	(63,038)	43
44	**TOTAL Special Cost Centers**	(63,038)	0	0	0	0	0	0	0	0	0	0	(63,038)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(238,764)	(4,367)	(283,393)	0	0	0	0	0	0	0	0	(526,524)	45

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 1/1/10 Ending: 12/31/10

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	PROFESSIONAL FEES	$ 80,000	PHC CONSULTANTS, LLC		$ 75,633	$ (4,367)	1
2	V								2
3	V	19	PROFESSIONAL FEES	3,015	MTS CONSULTING		3,015		3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 83,015			$ 78,648	$ * (4,367)	14

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

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 1/1/10 Ending: 12/31/10

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	HOME OFFICE	$ 494,400	PLATINUM HEALTH CARE, LLC	100.00%	$	$ (494,400)	15
16	V	5	Utilities		PLATINUM HEALTH CARE, LLC		5,867	5,867	16
17	V	6	Repairs & Maintenance		PLATINUM HEALTH CARE, LLC		5,504	5,504	17
18	V	17	Administrative Salary		PLATINUM HEALTH CARE, LLC		22,405	22,405	18
19	V	19	Professional Fees		PLATINUM HEALTH CARE, LLC		9,101	9,101	19
20	V	20	Fees, Subscriptions		PLATINUM HEALTH CARE, LLC		1,690	1,690	20
21	V	21	Clerical Salaries		PLATINUM HEALTH CARE, LLC		116,020	116,020	21
22	V	21	Office Expenses		PLATINUM HEALTH CARE, LLC		15,258	15,258	22
23	V	24	Education & Seminars		PLATINUM HEALTH CARE, LLC		519	519	23
24	V	25	Travel		PLATINUM HEALTH CARE, LLC		7,415	7,415	24
25	V	26	Insurance		PLATINUM HEALTH CARE, LLC		757	757	25
26	V	27	Employee Benefits		PLATINUM HEALTH CARE, LLC		16,623	16,623	26
27	V	30	Depreciation		PLATINUM HEALTH CARE, LLC		1,578	1,578	27
28	V	35	Equipment Rental		PLATINUM HEALTH CARE, LLC		307	307	28
29	V	31	Amortization		PLATINUM HEALTH CARE, LLC		412	412	29
30	V	30	Depreciation		PLATINUM HEALTH CARE, LLC		2,074	2,074	30
31	V	32	Interest		PLATINUM HEALTH CARE, LLC		3,506	3,506	31
32	V	33	Real Estate Taxes		PLATINUM HEALTH CARE, LLC		1,971	1,971	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 494,400			$ 211,007	$ * (283,393)	39

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

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	BEN KLEIN		Administrative	33.33	SEE ATTACHED	2	6.45	Mgt Fees	$		1
2	BRIAN LEVINSON		Administrative	33.33	SEE ATTACHED	6	15.00	Mgt Fees			2
3	MARK SHAPIRO		Administrative	33.33	SEE ATTACHED	8	20.00	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: 1/1/10 Ending: 12/31/10

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 [X] NO [ ]

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

Name of Related Organization: PLATINUM HEALTH CARE, LLC
Street Address: 7444 LONG AVENUE
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847) 329-4100
Fax Number: (847) 329-7652

	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	5	Utilities	Patient Days	581,243	18	$ 52,068	$	65,489	$ 5,867	1
2	6	Repairs & Maintenance	Patient Days	581,243	18	48,848		65,489	5,504	2
3	17	Administrative Salary	Patient Days	581,243	18	198,854	198,854	65,489	22,405	3
4	19	Professional Fees	Patient Days	581,243	18	80,779		65,489	9,101	4
5	20	Fees, Subscriptions	Patient Days	581,243	18	15,003		65,489	1,690	5
6	21	Clerical Salaries	Patient Days	581,243	18	1,029,725	1,029,725	65,489	116,020	6
7	21	Office Expenses	Patient Days	581,243	18	135,424		65,489	15,258	7
8	24	Education & Seminars	Patient Days	581,243	18	4,602		65,489	519	8
9	25	Travel	Patient Days	581,243	18	65,815		65,489	7,415	9
10	26	Insurance	Patient Days	581,243	18	6,717		65,489	757	10
11	27	Employee Benefits	Patient Days	581,243	18	147,536		65,489	16,623	11
12	30	Depreciation	Patient Days	581,243	18	14,004		65,489	1,578	12
13	35	Equipment Rental	Patient Days	581,243	18	2,729		65,489	307	13
14	31	Amortization	Patient Days	581,243	18	3,657		65,489	412	14
15	30	Depreciation	Patient Days	581,243	18	18,405		65,489	2,074	15
16	32	Interest	Patient Days	581,243	18	31,121		65,489	3,506	16
17	33	Real Estate Taxes	Patient Days	581,243	18	17,492		65,489	1,971	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,872,779	$ 1,228,579		$ 211,007	25

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 1/1/10 Ending: 12/31/10

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	FIRST BANK		X	LINE OF CREDIT							41,041	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 41,041	9
	B. Non-Facility Related*											
10	INTEREST INCOME OFFSET										(17,784)	10
11												11
12												12
13	ALLOCATION FROM PLATINUM										3,506	13
14	TOTAL Non-Facility Related						$	$			$ (14,278)	14
15	TOTALS (line 9+line14)						$	$			$ 26,763	15

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

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

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

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 105,000	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.)		$ 68,429	2
3. Under or (over) accrual (line 2 minus line 1).		$ (36,571)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 72,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 35,429	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	101,683	8
	2006	103,293	9
	2007	100,784	10
	2008	77,417	11
	2009	68,429	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CAPITOL CARE CENTER COUNTY SANGAMON

FACILITY IDPH LICENSE NUMBER 0045666

CONTACT PERSON REGARDING THIS REPORT DARRYL BUEKER

TELEPHONE (417) 865-8701 FAX #: (417) 865-0682

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-28.0-401-018	Long Term Care Property	$ 64,773.38	$ 64,773.38
2.	14-28.0-401-006	Long Term Care Property	$ 3,655.42	$ 3,655.42
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 68,428.80	$ 68,428.80

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 and 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 1/1/10 Ending: 12/31/10

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. [X] (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. [X] (c) Rent equipment from Completely Unrelated Organization.

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

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

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	AWNING			2001	6,950		20	348	348	3,190	9
10	SIGNS & BANNERS			2001	4,354		10	435	435	3,951	10
11	A/C			2002	505		5	101	101	606	11
12	A/C			2002	5,263		7	752	752	6,015	12
13	MASONRY RESTORATION			2002	4,098		10	410	410	3,485	13
14	CEILING WORK			2002	1,500		20	75	75	675	14
15	CEILING WORK			2002	1,835		20	92	92	812	15
16	DOORS			2002	5,665		10	567	567	4,725	16
17	INSTALL GLASS			2002	735		10	74	74	666	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	1,015	19
20	INSTALL GLASS			2002	550		10	55	55	477	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	1,282	23
24	WATER HEATER			2002	10,018		12	835	835	7,306	24
25	THERMOSTAT REPAIR			2002	2,287		10	229	229	2,023	25
26	THERMOSTAT REPAIR			2002	825		10	83	83	685	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	2,439	28
29	INSTALL SIGNS			2002	718		10	72	72	648	29
30	ACCESS CONTROL SYSTEM			2002	3,482		10	348	348	3,132	30
31	ACCESS CONTROL SYSTEM			2002	2,646		10	265	265	2,385	31
32	ACCESS CONTROL SYSTEM			2002	588		10	59	59	526	32
33	INSTALL SIGNS			2002	977		10	98	98	865	33
34	SHOWER & GUARD RAILS			2002	535		20	27	27	223	34
35	CALL CORDS			2002	599		20	30	30	260	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: 1/1/10 Ending: 12/31/10

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	
37	RAIL POST	2002	$ 540	$	20	$ 27	$ 27	$ 227	37
38	CURTAIN FOR MAIN DINING ROOM	2003	849		5	170	170	1,019	38
39	REPLACEMENT FOR ZONAIRE	2003	5,565		20	278	278	2,016	39
40	FURNISH & INSTALL NEW CONDENSER	2003	1,521		20	76	76	545	40
41	A/C UNIT	2003	1,100		5	220	220	1,320	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	3,369	43
44	ALTERNATE FLOOR FIRE SVCS	2004	3,255		10	326	326	2,200	44
45	OVERHAUL 2 ELEVATORS	2004	40,080		20	2,004	2,004	13,193	45
46	CARPET	2004	9,720		5	1,944	1,944	11,664	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	1,170	48
49	CARPET	2005	5,754		5	1,151	1,151	5,947	49
50	FIRE SPRINKLERS	2006	7,867		25	315	315	1,496	50
51	REPAIRED DRAIN	2006	2,758		20	138	138	655	51
52	10-A/C FAN BLADES	2006	1,001		10	100	100	467	52
53	SOLAR CONTROL WINDOW	2006	1,442		10	144	144	636	53
54	DRIER & CONDENSER	2006	2,093		10	209	209	906	54
55	DRAIN PIPE & SHOWER VALVE	2006	2,277		20	114	114	494	55
56	DOORS	2006	6,806		20	340	340	1,360	56
57	RED OAK HARDWARE	2007	2,595		20	130	130	498	57
58	PLUMBING REPAIRS AND PART	2007	3,859		20	193	193	724	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	1,078	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	1,243	62
63	CONCRETE REPLACEMENT	2007	8,333		15	556	556	1,992	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	2,497	66
67	AIR HANDLER	2007	6,036		20	302	302	1,032	67
68	CONCRETE REPLACEMENT	2007	9,127		15	608	608	2,027	68
69	2 A/C UNITS - 3RD & 4TH FL (REMOVE $2,452 PER 2008 CAP	2007			5				69
70	TOTAL (lines 4 thru 69)		$ 215,647	$		$ 16,964	$ 16,964	$ 107,161	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: 1/1/10 Ending: 12/31/10

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	Totals from Page 12A, Carried Forward		$ 215,647	$		$ 16,964	$ 16,964	$ 107,161	1
2	PIPE RAIL	2007	8,250		15	550	550	1,788	2
3	CONCRETE REPLACEMENT	2007	11,377		15	758	758	2,400	3
4	ELECTRICAL-OUTSIDE LIGHTS TO CODE	2007	2,328		10	233	233	738	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	5,935	8
9	120 LIGHTS	2007	3,098		10	310	310	930	9
10	FOOTINGS/CONCRETE RETAINING WALLS	2008	22,994		20	1,150	1,150	2,683	10
11	35' RETAINING WALL (REMOVE $1,650 FROM $7,350 PER 20	2008	5,700		15	380	380	842	11
12	REMOVE/REBUILD WALL IN BUSINESS OFFICE (REMOVE	2008			15				12
13	VINYL FLOORING	2008	56,535		10	5,654	5,654	15,548	13
14	WAINSCOTING IN DINING AREA	2008	30,050		15	2,003	2,003	4,841	14
15	REPLACE 10 CHANDELIERS	2008	3,487		10	349	349	1,018	15
16	TV RESIDENCE ROOMS (REMOVE $2,000 PER 2009 CAP CO	2008			10				16
17	(6) 23" LCD/(1) 26" LCD & TV MOUNTS	2008	2,791		10	279	279	767	17
18	(14) SHELF WHT WIRE & CLIPS (REMOVE $1,052 PER 2008 C	2008			15				18
19	(4)LOCKNETICS DOOR MAGNETS	2008	5,230		10	523	523	1,395	19
20	(2) LOCKNETICS DOOR MAGNETS	2008	2,446		10	245	245	612	20
21	INDOOR KEYPAD/EXIT SENSOR	2008	3,255		10	326	326	733	21
22	KEYPAD ACCESS, CAMERA & MULTIPLEXER	2008	5,159		10	516	516	1,075	22
23	TILE - BACK SPLASH (REMOVE $1,260 PER 2008 CAP COST	2008			10				23
24	(4) 23" LCD TV, (3) MOUNTS (REMOVE $1,552 PER 2009 CAP	2008			10				24
25	(34) CUBICLE CURTAINS	2008	2,680		5	536	536	1,385	25
26	ASCOWITCH AUTO TRANSFER SWITCH	2008	2,623		15	175	175	452	26
27	(6) ZONELINE HEAT/COOL	2008	4,176		15	278	278	718	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	1,170	29
30	COMPRESSOR 12,000 BTU (REMOVE $2,163 PER 2009 CAP C	2008			12				30
31	STAINLESS STEEL RECEIVER ON WALK-IN COOLER (REM	2008			10				31
32	CEMENT/BLACKTOP	2008	2,500		8	313	313	756	32
33	SINK/DRAIN PIPING (REMOVE $2,195 PER 2009 CAP COST A	2008			10				33
34	TOTAL (lines 1 thru 33)		$ 426,223	$		$ 33,935	$ 33,935	$ 152,945	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: 1/1/10 Ending: 12/31/10

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	Totals from Page 12B, Carried Forward		$ 426,223	$		$ 33,935	$ 33,935	$ 152,945	1
2	LIGHT BULBS (REMOVE $4,914 PER 2009 CAP COST AUDIT	2008	4,914		5	983	983	2,457	2
3	TRANSFER SWITCH (REMOVE $1,354 PER CAP COST AUDI	2008			15				3
4	A/C WORK (REMOVE $1,762 OF $5,781 PER 2009 CAP COST A	2008	4,019		15	268	268	761	4
5	LIGHT FIXTURES (REMOVE $1,578 PER 2009 CAP COST AU	2008			10				5
6	(34) CUBICLE CURTAINS	2008	2,680		5	536	536	1,340	6
7	ROUTER/PRINTER/INSTALL	2008	5,179		5	1,036	1,036	2,504	7
8	CARPET	2008	432		5	86	86	516	8
9	FRONT RAILING	2008	15,466		15	1,031	1,031	2,406	9
10	(25) FO32T8/SUPER 741 (REMOVE $3,000 PER 2009 CAP COST	2008			15				10
11	DOOR PARTS--CLOSERS/HINGES (REMOVE $1,590 PER 200	2008			20				11
12	ROCK FOR PARKING LOT & LANDSCAPING (REMOVE $53	2008			5				12
13	KITCHEN DOOR (REMOVE $1,008 PER 2009 CAP COST AUD	2008			20				13
14	DOORS - 2ND FLOOR (REMOVE $885 PER 2009 CAP COST A	2008			15				14
15	42" DOOR W/SIDELITE	2008	4,401		15	293	293	635	15
16	DOOR OPERATOR BY STANLEY	2008	2,805		15	187	187	405	16
17	ARCHITECTURAL SERVICES (REMOVE $3,600 PER 2009 CA	2008			20				17
18	KEYPAD & RELAY MODULE	2009	2,584		10	258	258	495	18
19	2 DOORS	2009	1,159		15	77	77	141	19
20	50 LIFE SAFETY ACCESS DOOR	2009	5,700		15	380	380	697	20
21	DSL INSTALLATION	2009	5,688		20	284	284	474	21
22	A/C UNITS	2009	7,488		10	749	749	1,248	22
23	3 UNITS	2009	4,663		10	466	466	777	23
24	WALL REPAIR & REPLACEMENT	2009	10,575		20	529	529	837	24
25	10 UNITS	2009	15,544		10	1,554	1,554	2,461	25
26	ASPHALT DRIVE & PARKING LOT	2009	41,200		8	5,150	5,150	8,154	26
27	FLOORING	2009	1,405		10	141	141	200	27
28	NEW SIGNS & AWNING PANEL	2009	4,997		10	500	500	667	28
29	3 CLEAR GLASS IN	2009	1,340		20	67	67	89	29
30	CONCRETE HANDICAPPED	2009	6,000		15	400	400	533	30
31	REPAIR STAIRWELL DOOR	2009	2,689		20	134	134	168	31
32	WHEELCHAIR RAMP & CONCRETE	2009	1,850		15	123	123	144	32
33	MASONRY	2009	1,350		15	90	90	105	33
34	TOTAL (lines 1 thru 33)		$ 580,351	$		$ 49,257	$ 49,257	$ 181,159	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: 1/1/10 Ending: 12/31/10

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	Totals from Page 12C, Carried Forward		$ 580,351	$		$ 49,257	$ 49,257	$ 181,159	1
2	ELEVATOR WORK	2009	14,500		20	725	725	846	2
3	NEW ALMINUM DOOR	2009	2,975		20	149	149	161	3
4	2 SMOKE DETECTORS & DOOR	2009	2,310		10	231	231	250	4
5	FIRE SPRINLKER SYSTEM	2009	2,816		25	113	113	122	5
6	ELECTRICAL WORK	2009	3,797		20	190	190	190	6
7	LARGE ARBOR VIDAE	2009	1,063		15	71	71	124	7
8	TINTS FOR KITCHEN	2009	767		20	38	38	38	8
9	3 CARBON DIOXIDE DETECTORS	2010	3,885		10	356	356	356	9
10	CARD ACCESS SYSTEM	2010	11,875		10	989	989	989	10
11	4 MCQUAY COOLING CHASSIS	2010	6,888		10	390	390	390	11
12	REPAIR WASTE PIPING-CONTRACT-MIKE WILLIAMS PLU	2010	3,714		25	102	102	102	12
13	COMPRESSOR - 10 TON UNIT	2010	3,983		10	232	232	232	13
14	3 MCQUAY COOLING CHASSIS	2010	4,762		10	198	198	198	14
15	3 MCQUAY COOLING CHASSIS	2010	4,762		10	159	159	159	15
16	PLUMBING-CONTRACT-E.L. PRUITT	2010	2,500		20	42	42	42	16
17	MODERNIZATION-LONG ELEVATOR & MACHINE CO	2010	17,600		20				17
18				86,243			(86,243)		18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30	ALLOCATION FROM PLATINUM HEALTH CARE			1,576		1,576			30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 668,548	$ 87,819		$ 54,818	$ (33,001)	$ 185,358	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: 1/1/10 Ending: 12/31/10

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	$ 625,471	$ 35,250	$ 60,788	$ 25,538		$ 344,585	71
72	Current Year Purchases	57,841	36,340	4,175	(32,165)		4,175	72
73	Fully Depreciated Assets							73
74	Allocation from Platinum		2,076	2,076				74
75	TOTALS	$ 683,312	$ 73,666	$ 67,039	$ (6,627)		$ 348,760	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)	$ 1,351,860	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 161,485	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 121,857	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (39,628)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 534,118	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 1/1/10 Ending: 12/31/10

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. [X] 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:				$ 967,683			3
4	Additions							4
5								5
6								6
7	TOTAL				$ 967,683 **			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: *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ $123,560 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	$ 30,940	17
18					18
19					19
20					20
21	TOTAL		$	$ 30,940	21

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

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

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 1/1/10 Ending: 12/31/10

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-03	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	10a-03	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-03	hrs		1,903	108,564		1,903	108,564	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				481,595		481,595	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Lab	39-02					26,627		26,627	13
14	TOTAL			$	1,903	$ 108,564	$ 508,222	1,903	$ 616,786	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.

STATE OF ILLINOIS

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 1/1/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (235,430)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,889,685		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	239,000		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Medicare	269,364		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,162,619	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	744,367		15
16	Equipment, at Historical Cost	667,523		16
17	Accumulated Depreciation (book methods)	(1,050,326)		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): Due Others	586,005		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 947,569	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,110,188	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,204,727	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	312,767		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	72,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	57,810		36
37	Due Others & Adv Billing	297,845		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,945,149	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	100,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 100,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,045,149	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 65,039	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,110,188	$	48

*(See instructions.)

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 671,158	1
2	Restatements (describe):		2
3	PRIOR PERIOD ADJUSTMENT	(142,382)	3
4	ROUNDING	1	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 528,777	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	511,262	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	(975,000)	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)**	$ (463,738)	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)**	$ 65,039	24 *

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

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 1/1/10 Ending: 12/31/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,287,985	1
2	Discounts and Allowances for all Levels	(399,359)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,888,626	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,802,836	6
7	Oxygen	1,240	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,804,076	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	623,669	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	22,104	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 645,773	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	17,784	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 17,784	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	TRANSPORTATION, VENDING, MISC INCOME	11,366	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 11,366	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,367,625	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,050,100	31
32	Health Care	4,235,392	32
33	General Administration	2,568,740	33
	B. Capital Expense		
34	Ownership	1,356,486	34
	C. Ancillary Expense		
35	Special Cost Centers	508,222	35
36	Provider Participation Fee	137,423	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,856,363	40
41	**Income before Income Taxes (line 30 minus line 40)****	511,262	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 511,262	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: 1/1/10 Ending: 12/31/10

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,885	2,014	$ 69,681	$ 34.60	1
2	Assistant Director of Nursing	9,582	10,359	274,962	26.54	2
3	Registered Nurses	16,040	17,074	441,240	25.84	3
4	Licensed Practical Nurses	36,225	42,551	766,314	18.01	4
5	CNAs & Orderlies	125,954	130,948	1,372,954	10.48	5
6	CNA Trainees					6
7	Licensed Therapist	8,721	9,372	322,206	34.38	7
8	Rehab/Therapy Aides	11,371	12,984	394,749	30.40	8
9	Activity Director	1,792	1,869	24,157	12.93	9
10	Activity Assistants	3,823	4,053	40,161	9.91	10
11	Social Service Workers	6,183	6,539	107,075	16.37	11
12	Dietician					12
13	Food Service Supervisor	1,860	2,238	40,129	17.93	13
14	Head Cook					14
15	Cook Helpers/Assistants	36,673	38,490	368,598	9.58	15
16	Dishwashers					16
17	Maintenance Workers	12,764	15,751	176,036	11.18	17
18	Housekeepers	23,459	24,682	252,191	10.22	18
19	Laundry	13,235	14,482	140,495	9.70	19
20	Administrator	1,830	2,169	143,423	66.12	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,610	19,034	289,429	15.21	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	1,803	1,964	34,292	17.46	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	330,810	356,573	$ 5,258,092 *	$ 14.75	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	336	$ 16,081	01-03	35
36	Medical Director	Monthly	30,000	09-03	36
37	Medical Records Consultant	Quarterly	1,760	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant		15,595	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	10	578	11-03	44
45	Social Service Consultant	7	465	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	353	$ 64,479		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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 # 0045666 Report Period Beginning: 1/1/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
CYNTHIA SCHAAF	ADMINISTRATOR		$ 143,423
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 143,423

B. Administrative - Other

Description	Amount
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
SEE ATTACHED SCHEDULE		$ 219,092
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 219,092

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 167,108
Unemployment Compensation Insurance	118,069
FICA Taxes	381,586
Employee Health Insurance	172,066
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K	931
EMPLOYEE BENEFITS-OTHER	6,854
EMPLOYEE PHYSICAL EXAM	5,500
TOTAL (agree to Schedule V, line 22, col.8)	$ 852,114

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	6,424
Health Care Worker Background Check	3,901
(Indicate # of checks performed 94)	
Patient Background Checks 256	
ADVERTISING & MARKETING	51,609
DUES & SUBSCRIPTIONS	16,929
LICENSES	7,108
ALLOCATION FROM PLATINUM	1,690
Less: Public Relations Expense	( )
Non-allowable advertising	(51,609)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 36,052

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	18,667
ALLOCATION FROM PLATINUM	519
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 19,186

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 1/1/10 Ending: 12/31/10

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 1/1/10 Ending: 12/31/10

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 $20,745**

(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. $ **336** 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? **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?
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 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.