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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0050526

Facility Name: Central Nursing & Rehab Ctr

Address: 2450 N Central Ave (Number) Chicago (City) 60639 (Zip Code)

County: Cook

Telephone Number: 773-889-1333 **Fax #** 773-889-1516

HFS ID Number:

Date of Initial License for Current Owners: 09/01/2009

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	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: Alan Sorscher **Telephone Number:** 708-449-1900
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 01/01/2012 to 12/31/2012 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) Alan Sorscher
(Title) CFO

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) Fax # ( )

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Central Nursing & Rehab Ctr # 0050526 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 n/a

	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	245	Skilled (SNF)	245	89,670	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	245	TOTALS	245	89,670	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	76,083	9	4,913	81,005	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	76,083	9	4,913	81,005	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.34%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

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 09/01/2009

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 09/01/2009 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 245 and days of care provided 4,535

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Central Nursing & Rehab Ctr # 0050526 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	258,071	35,480	15,000	308,551		308,551	(5,001)	303,550			1
2	Food Purchase		315,008		315,008		315,008		315,008			2
3	Housekeeping	229,443	29,696		259,139		259,139		259,139			3
4	Laundry	17,646	13,811		31,457		31,457		31,457			4
5	Heat and Other Utilities			182,858	182,858		182,858	639	183,497			5
6	Maintenance	30,805	26,336	93,238	150,379		150,379	(1,641)	148,738			6
7	Other (specify):*											7
8	TOTAL General Services	535,965	420,331	291,096	1,247,392		1,247,392	(6,003)	1,241,389			8
	B. Health Care and Programs											
9	Medical Director			11,000	11,000		11,000		11,000			9
10	Nursing and Medical Records	2,464,568	210,881	31,650	2,707,099		2,707,099	14,237	2,721,336			10
10a	Therapy			418,758	418,758		418,758		418,758			10a
11	Activities	91,372	19,424		110,796		110,796		110,796			11
12	Social Services	99,074		11,458	110,532		110,532		110,532			12
13	CNA Training											13
14	Program Transportation			1,760	1,760		1,760		1,760			14
15	Other (specify):* Pharmacy Consultant			21,663	21,663		21,663		21,663			15
16	TOTAL Health Care and Programs	2,655,014	230,305	496,289	3,381,608		3,381,608	14,237	3,395,845			16
	C. General Administration											
17	Administrative	93,035			93,035		93,035		93,035			17
18	Directors Fees											18
19	Professional Services			1,074,467	1,074,467		1,074,467	(248,464)	826,003			19
20	Dues, Fees, Subscriptions & Promotions			13,561	13,561		13,561		13,561			20
21	Clerical & General Office Expenses	181,981	78,132	26,076	286,189		286,189	58,087	344,276			21
22	Employee Benefits & Payroll Taxes			619,206	619,206		619,206	70,783	689,989			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,648	6,648		6,648	262	6,910			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			111,515	111,515		111,515	118,445	229,960			26
27	Other (specify):*											27
28	TOTAL General Administration	275,016	78,132	1,851,473	2,204,621		2,204,621	(887)	2,203,734			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,465,995	728,768	2,638,858	6,833,621		6,833,621	7,347	6,840,968			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Central Nursing & Rehab Ctr #0050526 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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			46,020	46,020		46,020	465,068	511,088			30
31	Amortization of Pre-Op. & Org.							15,828	15,828			31
32	Interest			141,317	141,317		141,317	1,120,960	1,262,277			32
33	Real Estate Taxes							328,265	328,265			33
34	Rent-Facility & Grounds			2,700,000	2,700,000		2,700,000	(2,693,302)	6,698			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Replacement Tax			23,741	23,741		23,741	1,067,832	1,091,573			36
37	TOTAL Ownership			2,911,078	2,911,078		2,911,078	304,651	3,215,729			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		164,955		164,955		164,955		164,955			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			958,698	958,698		958,698		958,698			42
43	Other (specify):* Bad Debt Expense			500,000	500,000		500,000		500,000			43
44	TOTAL Special Cost Centers		164,955	1,458,698	1,623,653		1,623,653		1,623,653			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,465,995	893,723	7,008,634	11,368,352		11,368,352	311,998	11,680,350			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Central Nursing & Rehab Ctr # 0050526 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	71,580	30		9
10	Interest and Other Investment Income	(386)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(1,017)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule misc inc	3,474	various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 73,651		$	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)	238,347	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 238,347		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 311,998		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

SEE ACCOUNTANTS' COMPILATION REPORT

Central Nursing & Rehab Ctr

ID# 0050526

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	misc inc	$ 3,474	19	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	3,474		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Central Nursing & Rehab Ctr **#** 0050526 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	(5,001)	0	0	0	0	0	0	0	0	0	(5,001)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	639	0	0	0	0	0	0	0	0	0	639	5
6	Maintenance	0	(1,641)	0	0	0	0	0	0	0	0	0	(1,641)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	(6,003)	0	0	0	0	0	0	0	0	0	(6,003)	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	14,237	0	0	0	0	0	0	0	0	0	14,237	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	14,237	0	0	0	0	0	0	0	0	0	14,237	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	3,474	(256,938)	5,000	0	0	0	0	0	0	0	0	(248,464)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(1,017)	56,314	2,790	0	0	0	0	0	0	0	0	58,087	21
22	Employee Benefits & Payroll Taxes	0	70,783	0	0	0	0	0	0	0	0	0	70,783	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	262	0	0	0	0	0	0	0	0	0	262	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	434	118,011	0	0	0	0	0	0	0	0	118,445	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	2,457	(129,145)	125,801	0	0	0	0	0	0	0	0	(887)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	2,457	(120,911)	125,801	0	0	0	0	0	0	0	0	7,347	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Central Nursing & Rehab Ctr **#** 0050526 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	71,580	164	393,324	0	0	0	0	0	0	0	0	465,068	30
31	Amortization of Pre-Op. & Org.	0	0	15,828	0	0	0	0	0	0	0	0	15,828	31
32	Interest	(386)	0	1,121,346	0	0	0	0	0	0	0	0	1,120,960	32
33	Real Estate Taxes	0	0	328,265	0	0	0	0	0	0	0	0	328,265	33
34	Rent-Facility & Grounds	0	6,698	(2,700,000)	0	0	0	0	0	0	0	0	(2,693,302)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	1,067,832	0	0	0	0	0	0	0	0	1,067,832	36
37	TOTAL Ownership	71,194	6,862	226,595	0	0	0	0	0	0	0	0	304,651	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	73,651	(114,049)	352,396	0	0	0	0	0	0	0	0	311,998	45

Facility Name & ID Number Central Nursing & Rehab Ctr # 0050526 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Moishe Gubin	50%			Infinity Healthcare	Hillside, Il	Management Co.
Michael Blisko	50%					

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	1	Dietary	$ 15,000	Infinity Healthcare Management		$ 9,999	$ (5,001)	1
2	V	6	Maint	5,675	Infinity Healthcare Management		4,034	(1,641)	2
3	V	10	Nursing	25,200	Infinity Healthcare Management		39,437	14,237	3
4	V	19	Professional Services	258,000	Infinity Healthcare Management		1,062	(256,938)	4
5	V	5	Utilities		Infinity Healthcare Management		639	639	5
6	V	21	Office Expense	33,477	Infinity Healthcare Management		89,791	56,314	6
7	V	22	Employee Expense	4,200	Infinity Healthcare Management		74,983	70,783	7
8	V	26	Insurance		Infinity Healthcare Management				8
9	V	34	Rent		Infinity Healthcare Management				9
10	V	30	Depreciation		Infinity Healthcare Management		164	164	10
11	V	24	Travel/Seminar		Infinity Healthcare Management		262	262	11
12	V	26	Insurance		Infinity Healthcare Management		434	434	12
13	V	34	Rent		Infinity Healthcare Management		6,698	6,698	13
14	Total			$ 341,552			$ 227,503	$ * (114,049)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Central Nursing & Rehab Ctr # 0050526 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 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	21	Office Expense	$	Central Nursing Realty, LLC		$ 2,790	$ 2,790	15
16	V	26	Insurance		Central Nursing Realty, LLC		118,011	118,011	16
17	V	30	Depreciation		Central Nursing Realty, LLC		393,324	393,324	17
18	V	31	Amortization of Org. Costs		Central Nursing Realty, LLC		15,828	15,828	18
19	V	32	Mortgage Interest		Central Nursing Realty, LLC		1,121,346	1,121,346	19
20	V	33	Property Taxes		Central Nursing Realty, LLC		328,265	328,265	20
21	V	36	Amortization of Goodwill		Central Nursing Realty, LLC		1,067,832	1,067,832	21
22	V	34	Rent	2,700,000	Central Nursing Realty, LLC			(2,700,000)	22
23	V	19	Accounting		Central Nursing Realty, LLC		5,000	5,000	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 2,700,000			$ 3,052,396	$ * 352,396	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Central Nursing & Rehab Ctr # 0050526 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Central Nursing & Rehab Ctr # 0050526 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1									$		1
2											2
3											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**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Central Nursing & Rehab Ctr # 0050526 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Central Nursing & Rehab Ctr # 0050526 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	Housing & Healthcare Finance		x	Facility	$113,977.00	8/1/2009	$ 21,250,000	$ 20,536,546	9/1/2044	0.0549	$ 1,121,346	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bank Leumi		x	Working Capital	none	2/3/10	2,500,000	1,549,000	5/15/13	variable	99,095	6
7	Infinity Funding	x		Working Capital	none	various	660,000	660,000	various	various	42,222	7
8												8
9	TOTAL Facility Related				$113,977.00		$ 24,410,000	$ 22,745,546			$ 1,262,663	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 24,410,000	$ 22,745,546			$ 1,262,663	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.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** 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 Central Nursing & Rehab Ctr # 0050526 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 274,279	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.)		$ 333,386	2
3. Under or (over) accrual (line 2 minus line 1).		$ 59,107	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 269,158	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.		$ 328,265	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2007		8
2008		9
2009	292,045	10
2010	334,779	11
2011	333,386	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Central Nursing & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050526

CONTACT PERSON REGARDING THIS REPORT Alan Sorscher

TELEPHONE 708-449-1900 FAX #: 773-889-1516

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

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-29-431-013-0000	Nursing Facility	$ 18,657.03	$ 18,657.03
2.	13-29-431-014-0000	Nursing Facility	$ 45,702.37	$ 45,702.37
3.	13-29-431-015-0000	Nursing Facility	$ 45,766.90	$ 45,766.90
4.	13-29-431-016-0000	Nursing Facility	$ 45,987.72	$ 45,987.72
5.	13-29-431-017-0000	Nursing Facility	$ 45,716.66	$ 45,716.66
6.	13-29-431-018-0000	Nursing Facility	$ 45,702.37	$ 45,702.37
7.	13-29-431-019-0000	Nursing Facility	$ 45,445.22	$ 45,445.22
8.	13-29-431-020-0000	Nursing Facility	$ 36,265.60	$ 36,265.60
9.	13-29-431-021-0000	Nursing Facility	$ 2,043.22	$ 2,043.22
10.	13-29-431-022-0000	Nursing Facility	$ 2,099.30	$ 2,099.30
		TOTALS	$ 333,386.39	$ 333,386.39

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

Facility Name & ID Number Central Nursing & Rehab Ctr # 0050526 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 86,088 B. General Construction Type: Exterior _____ Frame _____ Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (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? [x] (a) Own the Equipment [x] (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? [x] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 237,433 2. Number of Years Over Which it is Being Amortized: 15 years

3. Current Period Amortization: 15,828 4. Dates Incurred: prior to 9/1/09

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	facility		2009	$ 500,000	1
2					2
3	TOTALS			$ 500,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Central Nursing & Rehab Ctr # 0050526 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	245		2009		$ 6,982,500	$ 179,040		$ 179,040	$	$ 596,797	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Pylon Sign & Architectural Lettering/Logo			10/13/2009	9,886	253	39	253	0	845	9
10	Pylon Sign & Architectural Lettering/Logo			9/22/2009	4,654	119	39	119	0	396	10
11	Aluminum Sign & Architectural Lettering/Logo			9/22/2009	2,269	58	39	58	0	194	11
12	Aluminum Sign & Architectural Lettering/Logo			10/13/2009	4,638	119	39	119	(0)	396	12
13	Ceiling Tile			12/31/2009	1,837	47	39	47	0	157	13
14	Paint			8/27/2010	886	23	39	23	(0)	68	14
15	Flow Switch & Sprinkler Repairs			12/29/2010	759	19	39	19	0	58	15
16	Sprinkler Repairs/Checks			12/14/2010	725	19	39	19	(0)	56	16
17	Oil Line Replacement			6/9/2010	5,075	130	39	130	0	390	17
18	Installation of New Lighting Fixtures and Ceiling Tiles			1/21/2010	113,325	2,906	39	2,906	(0)	8,718	18
19	Wooden Fencing Installation			6/7/2010	9,950	255	39	255	0	766	19
20	Wrought-Iron Fencing Installation			6/7/2010	4,270	109	39	109	0	328	20
21	Tuckpointed Masonry Wall			6/21/2010	12,325	316	39	316	0	948	21
22	Tuckpointed Masonry Wall			7/12/2010	12,325	316	39	316	0	948	22
23	William Small			7/12/2010	16,800	431	39	431	(0)	1,293	23
24	Window Installations			7/28/2010	904	23	39	23	0	69	24
25	Window Installations			7/14/2010	904	23	39	23	0	69	25
26	Sewage Pumps, Fuses, High Water Alarm, and Switch			10/12/2010	3,906	100	39	100	0	300	26
27	Exhaust Pump Room and Repair Hole			2/9/2011	1,810	46	39	46	0	92	27
28	Repair Pumps			6/30/2011	1,100	28	39	28	0	56	28
29	Furnish & Install Glass on Second Floor			4/27/2011	448	11	39	11	0	22	29
30	Remove Faulty Compressor and Replace With New One			3/1/2011	3,565	91	39	91	0	182	30
31	Fix A/C System			6/8/2011	4,308	110	39	110	0	220	31
32	Repair Water Leak			7/13/2011	1,572	40	39	40	0	80	32
33	Install New Bearing in Cooling Tower			8/15/2011	3,634	93	39	93	0	186	33
34	Purchase Smoking Shelter			5/4/2011	4,775	122	39	122	0	244	34
35	Clean & Clear Debris from Window Well Drains			5/1/2011	1,688	43	39	43	0	86	35
36	Electrical Repairs from Moisture Infiltration			5/5/2011	487	12	39	12		24	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Central Nursing & Rehab Ctr # 0050526 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	Clear Drains of Blockage	5/12/2011	$ 5,945	$ 152	39	$ 152	$	$ 304	37
38	Replace Metal Exit Doors & Frames	5/12/2011	6,032	155	39	155		310	38
39	Repair Interior Moisture Damage	5/12/2011	4,414	113	39	113		226	39
40	Tuckpointing Work	4/7/2011	1,014	26	39	26		52	40
41	Remove & Replace Concrete	7/18/2011	3,900	100	39	100		200	41
42	Sprinkler Head Addition to Elevator Pit	10/6/2011	2,463	63	39	63		126	42
43	Repair floor in therapy room	11/18/2012	1,520	39	39	7	(32)	39	43
44	DVR and high resolution color cameras for TVs	8/7/2012	6,714	172	39	72	(100)	172	44
45	Upgrade phone system	8/7/2012	5,580	143	39	60	(83)	143	45
46	Infinity HCM	11/1/2012	26,079	669	39	111	(558)	669	46
47	Infinity HCM	12/1/2012	25,000	641	39	53	(588)	641	47
48	Infinity HCM	12/14/2012	32,579	835	39	67	(768)	835	48
49	Ejector Sewage Pump System	8/18/2011	15,246	391	39	157	(234)	391	49
50	Construction on lobby, nurses station, corridors, etc.	12/23/2012	295,793	7,585	39	609	(6,976)	7,585	50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,643,605	$ 195,990		$ 186,653	$ (9,337)	$ 625,681	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Central Nursing & Rehab Ctr # 0050526 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	$ 1,617,776	$ 230,754	$ 321,915	$ 91,161	5	$ 796,485	71
72	Current Year Purchases	12,600	12,600	2,520	(10,080)	5	12,600	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,630,376	$ 243,354	$ 324,435	$ 81,081		$ 809,085	75

D. Vehicle Costs. (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)	$ 9,773,981	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 439,344	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 511,088	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 71,744	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,434,766	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Central Nursing & Rehab Ctr # 0050526 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: n/a
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:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			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.	/2013	$
13.	/2014	$
14.	/2015	$

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: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Central Nursing & Rehab Ctr # 0050526 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Central Nursing & Rehab Ctr # 0050526 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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-3	hrs	$		$ 204,835	$		$ 204,835	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			79,932			79,932	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			133,991			133,991	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				151,900		151,900	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): lab and radiology						13,055		13,055	13
14	TOTAL			$		$ 418,758	$ 164,955		$ 583,713	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.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Central Nursing & Rehab Ctr # 0050526 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012 (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	$ (194,409)	$ 153,027	1
2	Cash-Patient Deposits	4,102	4,102	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,147,442	3,147,442	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	248,681	248,681	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,205,816	$ 3,553,252	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		500,000	13
14	Buildings, at Historical Cost		6,982,500	14
15	Leasehold Improvements, at Historical Cost	661,106	661,106	15
16	Equipment, at Historical Cost	130,376	1,630,376	16
17	Accumulated Depreciation (book methods)	(123,686)	(1,434,766)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		16,254,933	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(3,612,202)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 667,796	$ 20,981,947	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,873,612	$ 24,535,199	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,340,764	$ 1,340,764	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	407,066	407,066	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	working capital note	1,549,000	1,549,000	36
37	working capital note	660,000	660,000	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,956,830	$ 3,956,830	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		20,536,546	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)**	$	$ 20,536,546	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,956,830	$ 24,493,376	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (83,218)	$ 41,823	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,873,612	$ 24,535,199	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Central Nursing & Rehab Ctr # 0050526 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,318,795)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,318,795)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	431,365	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	804,212	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,235,577	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)**	$ (83,218)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Central Nursing & Rehab Ctr # 0050526 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,736,991	1
2	Discounts and Allowances for all Levels	1,002,021	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,739,012	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	63,793	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 63,793	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	386	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 386	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	misc revenue	(3,474)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (3,474)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,799,717	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,247,392	31
32	Health Care	3,381,608	32
33	General Administration	2,204,621	33
	B. Capital Expense		
34	Ownership	2,911,078	34
	C. Ancillary Expense		
35	Special Cost Centers	164,955	35
36	Provider Participation Fee	958,698	36
	D. Other Expenses (specify):		
37	bad debt expense	500,000	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,368,352	40
41	**Income before Income Taxes (line 30 minus line 40)****	431,365	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 431,365	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 10,023,347	44
45	Private Pay - Net Inpatient Revenue	16,668	45
46	Medicare - Net Inpatient Revenue	1,650,494	46
47	Other-(specify)		47
48	Other-(specify) commercial ins	48,503	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 11,739,012	49

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Central Nursing & Rehab Ctr # 0050526 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	1,960	2,180	$ 107,540	$ 49.33	1
2	Assistant Director of Nursing	8,416	9,158	244,992	26.75	2
3	Registered Nurses	30,788	33,550	925,122	27.57	3
4	Licensed Practical Nurses	15,270	16,400	337,877	20.60	4
5	CNAs & Orderlies	60,787	67,999	758,577	11.16	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,898	4,405	59,367	13.48	8
9	Activity Director					9
10	Activity Assistants	8,186	9,027	91,372	10.12	10
11	Social Service Workers	5,359	5,893	99,074	16.81	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	19,808	21,629	258,071	11.93	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,872	2,056	30,805	14.98	17
18	Housekeepers	18,381	20,973	229,445	10.94	18
19	Laundry	1,807	1,959	17,646	9.01	19
20	Administrator	1,952	2,080	93,035	44.73	20
21	Assistant Administrator					21
22	Other Administrative	1,944	2,080	37,470	18.01	22
23	Office Manager					23
24	Clerical	8,734	9,593	144,511	15.06	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	2,190	2,405	31,091	12.93	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	191,352	211,387	$ 3,465,995 *	$ 16.40	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	429	$ 15,000	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	633	31,650	10-3	38
39	Pharmacist Consultant	433	21,663	15-3	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	327	11,458	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,822	$ 79,771		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Central Nursing & Rehab Ctr # 0050526 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Phillip Morganstern	Admin		$ 93,035
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 93,035

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
bradley & associates	accounting	$ 7,930
johnson goldberg & brown	accounting	2,000
sandra thiel	legal	1,229
clark hill p.c.	legal	914
ambassador nursing	professional	12,186
infinity healthcare	professional	258,000
various	professional	792,208
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 1,074,467

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 79,015
Unemployment Compensation Insurance	80,461
FICA Taxes	270,207
Employee Health Insurance	158,995
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
pension expense	23,380
employee expense	72,673
uniforms	5,258
TOTAL (agree to Schedule V, line 22, col.8)	$ 689,989

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	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
licenses and fees	13,561
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,561

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
mileage	430
travel	5,062
Seminar Expense	1,418
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,910

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Central Nursing & Rehab Ctr # 0050526 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Central Nursing & Rehab Ctr # 0050526 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **no**
If YES, give association name and amount. **n/a**

(3) Did the nursing home make political contributions or payments to a political action organization? **no** If YES, have these costs been properly adjusted out of the cost report? **n/a**

(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? **5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **28,450** 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. **n/a**

(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. $ **958,698**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **no** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **n/a** Indicate the amount. $ **n/a**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **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? **no**
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? **no**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $ **n/a**

(17) Has an audit been performed by an independent certified public accounting firm? **no**
Firm Name: **n/a**

(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? **n/a**
Attach invoices and a summary of services for all architect and appraisal fees.