		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.

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT) FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

I. IDPH License ID Number: 0050526

Facility Name: Central Nrsg & Rehab Center

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	PROPRIETARY	GOVERNMENTAL
[ ] 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 1/1/13 to 12/31/13 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

Facility Name & ID Number Central Nrsg & Rehab Center # 0050526 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	245	Skilled (SNF)	245	89,425	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	89,425	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	75,407	129	4,603	80,139	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	75,407	129	4,603	80,139	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.62%

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) NINE

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 9/1/09

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 9/1/09 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 4,599

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: 12/31/13 Fiscal Year: 12/31/13

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

Facility Name & ID Number: Central Nrsg & Rehab Center # 0050526 Report Period Beginning: 1/1/13 Ending: 12/31/13

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	256,197	40,564	22,685	319,446		319,446	(8,974)	310,472			1
2	Food Purchase		323,245		323,245		323,245		323,245			2
3	Housekeeping	261,778	46,094		307,872		307,872		307,872			3
4	Laundry	19,989	12,489		32,478		32,478		32,478			4
5	Heat and Other Utilities			204,718	204,718		204,718	1,498	206,216			5
6	Maintenance	22,388	19,065	94,344	135,797		135,797	4,390	140,187			6
7	Other (specify):*											7
8	**TOTAL General Services**	560,352	441,457	321,747	1,323,556		1,323,556	(3,086)	1,320,470			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	2,594,833	205,633	35,407	2,835,873		2,835,873	3,852	2,839,725			10
10a	Therapy			481,378	481,378		481,378		481,378			10a
11	Activities	127,493	28,334		155,827		155,827		155,827			11
12	Social Services	98,369		9,831	108,200		108,200		108,200			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Pharmacy Consultant			23,607	23,607		23,607		23,607			15
16	**TOTAL Health Care and Programs**	2,820,695	233,967	562,223	3,616,885		3,616,885	3,852	3,620,737			16
	C. General Administration											
17	Administrative	95,291			95,291		95,291		95,291			17
18	Directors Fees											18
19	Professional Services			804,332	804,332		804,332	(218,749)	585,583			19
20	Dues, Fees, Subscriptions & Promotions			31,844	31,844		31,844	(387)	31,457			20
21	Clerical & General Office Expenses	94,246	81,256	24,595	200,097		200,097	85,928	286,025			21
22	Employee Benefits & Payroll Taxes			670,703	670,703		670,703	25,402	696,105			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,269	6,269		6,269	3,058	9,327			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			272,467	272,467		272,467	493	272,960			26
27	Other (specify):*											27
28	**TOTAL General Administration**	189,537	81,256	1,810,210	2,081,003		2,081,003	(104,255)	1,976,748			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,570,584	756,680	2,694,180	7,021,444		7,021,444	(103,489)	6,917,955			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.

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			474,571	474,571		474,571	269,762	744,333			30
31	Amortization of Pre-Op. & Org.			1,083,660	1,083,660		1,083,660		1,083,660			31
32	Interest			2,226,021	2,226,021		2,226,021	(2,936)	2,223,085			32
33	Real Estate Taxes			283,037	283,037		283,037		283,037			33
34	Rent-Facility & Grounds			2,700,000	2,700,000		2,700,000	(2,691,514)	8,486			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			6,767,289	6,767,289		6,767,289	(2,424,688)	4,342,601			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		127,646		127,646		127,646		127,646			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			588,366	588,366		588,366		588,366			42
43	Other (specify):* Bad Debt Expense			241,705	241,705		241,705	(241,705)				43
44	TOTAL Special Cost Centers		127,646	830,071	957,717		957,717	(241,705)	716,012			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,570,584	884,326	10,291,540	14,746,450		14,746,450	(2,769,882)	11,976,568			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 Central Nrsg & Rehab Center # 0050526 Report Period Beginning: 1/1/13 Ending: 12/31/13

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 Reference	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	270,148	30		9
10	Interest and Other Investment Income	(2,936)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(386)	30		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				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(241,705)	43		24
25	Fund Raising, Advertising and Promotional	(16,780)	21		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	(2,702,930)	various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (2,694,589)		$	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)	(75,293)	various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (75,293)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (2,769,882)		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.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Central Nrsg & Rehab Center

ID# 0050526

Report Period Beginning: 1/1/13

Ending: 12/31/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	interest income	$ (4,388)	21	1
2	misc income	1,458	21	2
3	rent	(2,700,000)	34	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
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45				45
46				46
47				47
48				48
49	**Total**	(2,702,930)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Central Nrsg & Rehab Center # 0050526 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	(8,974)	0	0	0	0	0	0	0	0	0	(8,974)	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	1,498	0	0	0	0	0	0	0	0	0	1,498	5
6	Maintenance	0	4,390	0	0	0	0	0	0	0	0	0	4,390	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	(3,086)	0	0	0	0	0	0	0	0	0	(3,086)	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	3,852	0	0	0	0	0	0	0	0	0	3,852	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	3,852	0	0	0	0	0	0	0	0	0	3,852	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	0	(218,749)	0	0	0	0	0	0	0	0	0	(218,749)	19
20	Fees, Subscriptions & Promotions	0	(387)	0	0	0	0	0	0	0	0	0	(387)	20
21	Clerical & General Office Expenses	(19,710)	105,638	0	0	0	0	0	0	0	0	0	85,928	21
22	Employee Benefits & Payroll Taxes	0	25,402	0	0	0	0	0	0	0	0	0	25,402	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	3,058	0	0	0	0	0	0	0	0	0	3,058	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	493	0	0	0	0	0	0	0	0	0	493	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(19,710)	(84,545)	0	0	0	0	0	0	0	0	0	(104,255)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(19,710)	(83,779)	0	0	0	0	0	0	0	0	0	(103,489)	29

Facility Name & ID Number Central Nrsg & Rehab Center # 0050526 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	269,762	0	0	0	0	0	0	0	0	0	0	269,762	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,936)	0	0	0	0	0	0	0	0	0	0	(2,936)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(2,700,000)	8,486	0	0	0	0	0	0	0	0	0	(2,691,514)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(2,433,174)	8,486	0	0	0	0	0	0	0	0	0	(2,424,688)	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):*	(241,705)	0	0	0	0	0	0	0	0	0	0	(241,705)	43
44	**TOTAL Special Cost Centers**	(241,705)	0	0	0	0	0	0	0	0	0	0	(241,705)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(2,694,589)	(75,293)	0	0	0	0	0	0	0	0	0	(2,769,882)	45

Facility Name & ID Number Central Nrsg & Rehab Center # 0050526 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	$ 18,655	Infinity Healthcare Management		$ 9,681	$ (8,974)	1
2	V	6	Maint		Infinity Healthcare Management		4,390	4,390	2
3	V	10	Nursing	29,282	Infinity Healthcare Management		33,134	3,852	3
4	V	22	Employee Exp	862	Infinity Healthcare Management		25,965	25,103	4
5	V	5	Utilities		Infinity Healthcare Management		1,498	1,498	5
6	V	21	Office Expense	16,655	Infinity Healthcare Management		122,102	105,447	6
7	V	19	Professional Services	219,810	Infinity Healthcare Management		1,061	(218,749)	7
8	V	21	Interest		Infinity Healthcare Management		191	191	8
9	V	22	Food	(299)	Infinity Healthcare Management			299	9
10	V	20	Licenses Fees	387	Infinity Healthcare Management			(387)	10
11	V	24	Travel/Seminar	98	Infinity Healthcare Management		3,156	3,058	11
12	V	26	Insurance		Infinity Healthcare Management		493	493	12
13	V	34	Rent		Infinity Healthcare Management		8,486	8,486	13
14	Total			$ 285,450			$ 210,157	$ * (75,293)	14

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

Facility Name & ID Number Central Nrsg & Rehab Center # 0050526 Report Period Beginning: 1/1/13 Ending: 12/31/13

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
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30								30

Facility Name & ID Number Central Nrsg & Rehab Center # 0050526 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	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

Facility Name & ID Number Central Nrsg & Rehab Center # 0050526 Report Period Beginning: 1/1/13 Ending: 12/31/13

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	HUD		x	Facility	$100,200.00	8/1/09	$ 21,250,000	$ 21,220,905	09/01/44	4.0200	$ 2,102,831	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Capital One		x	working capital	none	2/3/10	609,094	609,094	n/a	various	58,434	6
7	Infinity Funding	z		working capital	none	various	675,000	675,000	n/a	various	64,756	7
8												8
9	TOTAL Facility Related				$100,200.00		$ 22,534,094	$ 22,504,999			$ 2,226,021	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 22,534,094	$ 22,504,999			$ 2,226,021	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 Central Nrsg & Rehab Center # 0050526 Report Period Beginning: 1/1/13 Ending: 12/31/13

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Line	Description		Amount	
1	1. Real Estate Tax accrual used on 2012 report.	$	269,158	1
2	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.)	$	369,186	2
3	3. Under or (over) accrual (line 2 minus line 1).	$	100,028	3
4	4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)	$	183,009	4
5	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	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	7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	283,037	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2008		8
2009	292,045	9
2010	334,779	10
2011	333,386	11
2012	369,186	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Central Nrsg & Rehab Center 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 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-29-431-013-0000	Nursing Facility	$ 20,660.36	$ 20,660.36
2.	13-29-431-014-0000	Nursing Facility	$ 50,609.76	$ 50,609.76
3.	13-29-431-015-0000	Nursing Facility	$ 50,681.14	$ 50,681.14
4.	13-29-431-016-0000	Nursing Facility	$ 50,925.72	$ 50,925.72
5.	13-29-431-017-0000	Nursing Facility	$ 50,625.56	$ 50,625.56
6.	13-29-431-018-0000	Nursing Facility	$ 50,609.76	$ 50,609.76
7.	13-29-431-019-0000	Nursing Facility	$ 50,324.94	$ 50,324.94
8.	13-29-431-020-0000	Nursing Facility	$ 40,159.72	$ 40,159.72
9.	13-29-431-021-0000	Nursing Facility	$ 2,262.65	$ 2,262.65
10.	13-29-431-022-0000	Nursing Facility	$ 2,324.75	$ 2,324.75
		TOTALS	$ 369,184.36	$ 369,184.36

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 86,088   B. General Construction Type: Exterior BRICK 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? [ ] (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

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	facility		2009	$ 500,000	1
2					2
3	TOTALS			$ 500,000	3

Facility Name & ID Number Central Nrsg & Rehab Center # 0050526 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	39	$ 179,040	$	$ 775,837	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		1,100	9
10	Pylon Sign & Architectural Lettering/Logo			9/22/2009	4,654	119	39	119		516	10
11	Aluminum Sign & Architectural Lettering/Logo			9/22/2009	2,269	58	39	58		252	11
12	Aluminum Sign & Architectural Lettering/Logo			10/13/2009	4,638	119	39	119		515	12
13	Ceiling Tile			12/31/2009	1,837	47	39	47		204	13
14	Paint			8/27/2010	886	23	39	23		91	14
15	Flow Switch & Sprinkler Repairs			12/29/2010	759	19	39	19		77	15
16	Sprinkler Repairs/Checks			12/14/2010	725	19	39	19		75	16
17	Oil Line Replacement			6/9/2010	5,075	130	39	130		520	17
18	Installation of New Lighting Fixtures and Ceiling Tiles			1/21/2010	113,325	2,907	39	2,906	(1)	11,626	18
19	Wooden Fencing Installation			6/7/2010	9,950	255	39	255		1,021	19
20	Wrought-Iron Fencing Installation			6/7/2010	4,270	109	39	109		437	20
21	Tuckpointed Masonry Wall			6/21/2010	12,325	316	39	316		1,264	21
22	Tuckpointed Masonry Wall			7/12/2010	12,325	316	39	316		1,264	22
23	William Small			7/12/2010	16,800	431	39	431		1,725	23
24	Window Installations			7/28/2010	904	23	39	23		92	24
25	Window Installations			7/14/2010	904	23	39	23		92	25
26	Sewage Pumps, Fuses, High Water Alarm, and Switch			10/12/2010	3,906	100	39	100		400	26
27	Exhaust Pump Room and Repair Hole			2/9/2011	1,810	46	39	46		139	27
28	Repair Pumps			6/30/2011	1,100	28	39	28		84	28
29	Furnish & Install Glass on Second Floor			4/27/2011	448	11	39	11		33	29
30	Remove Faulty Compressor and Replace With New One			3/1/2011	3,565	91	39	91		274	30
31	Fix A/C System			6/8/2011	4,308	111	39	110	(1)	332	31
32	Repair Water Leak			7/13/2011	1,572	40	39	40		120	32
33	Install New Bearing in Cooling Tower			8/15/2011	3,634	93	39	93		280	33
34	Purchase Smoking Shelter			5/4/2011	4,775	123	39	122	(1)	368	34
35	Clean & Clear Debris from Window Well Drains			5/1/2011	1,688	43	39	43		129	35
36	Electrical Repairs from Moisture Infiltration			5/5/2011	487	12	39	12		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 Central Nrsg & Rehab Center # 0050526 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	$ 153	39	$ 152	$ (1)	$ 458	37
38	Replace Metal Exit Doors & Frames	5/12/2011	6,032	156	39	155	(1)	467	38
39	Repair Interior Moisture Damage	5/12/2011	4,414	113	39	113		340	39
40	Tuckpointing Work	4/7/2011	1,014	26	39	26		78	40
41	Remove & Replace Concrete	7/18/2011	3,900	100	39	100		300	41
42	Sprinkler Head Addition to Elevator Pit	10/6/2011	2,463	63	39	63		189	42
43	Repair floor in therapy room	11/18/2012	1,520	39	39	39		78	43
44	DVR and high resolution color cameras for TVs	8/7/2012	6,714	172	39	172		344	44
45	Upgrade phone system	8/7/2012	5,580	143	39	143		286	45
46	Vinyl flooring-corridors on floors 1-4 and basement therapy room	11/1/2012	26,079	669	39	669		1,338	46
47	New flooring & walls for therapy rooms	12/1/2012	25,000	641	39	641		1,282	47
48	New flooring, walls and carpeting for adminstration area	12/14/2012	32,579	835	39	835		1,670	48
49	Ejector Sewage Pump System	8/18/2011	15,246	391	39	391		782	49
50	Construction on lobby (new tile flooring, countertops, panels for								50
51	reception window, paint, window treatments, wall base), admissions								51
52	office (ceiling tile, light fixtures, carpeting, paint, wall base), basement								52
53	breakroom (new drywall partition w/ entry, fluorescent T-5 fixtures,								53
54	paint, window treatments), 1st floor nurses station & elevator lobby								54
55	(vinyl floor tile, wall base, new workstations for nurses, new sink and								55
56	faucet, and painting), 1st floor corridor (vinyl floor tile, wall base,								56
57	paint, window treatments, corner guards), 1st floor lounge (vinyl tile,								57
58	wall base, paint, corner guards, window treatments), 2nd floor nurses								58
59	station and elevator lobby (vinyl floor tile, wall base, new nurses								59
60	workstations, new sink and faucet, painting), 2nd floor corridor (vinyl								60
61	floor tile, wall base, handrail, paining, corner guards), 2nd floor lounge								61
62	(vinyl floor tile, wall base, painting, corner guards, window treatments),								62
63	3rd floor nurses station & elevator lobby (vinyl floor tile, wall base,								63
64	new nurses workstations, new sink and faucet, painting), 3rd floor								64
65	corridor (vinyl floor tile, wall base, handrail, painting, corner guards)								65
66	3rd floor lounge (vinyl floor tile, wall base, painting corner guards,								66
67	window treatments), 4th floor nurses station & elevator lobby (vinyl								67
68	floor tile, wall base, nurses workstations, sink and faucet, painting),								68
69	CONTRUCTION PROJECTS CONTINUED ON NEXT PAGE								69
70	TOTAL (lines 4 thru 69)		$ 7,347,812	$ 188,406		$ 188,401	$ (5)	$ 806,515	70

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

Facility Name & ID Number Central Nrsg & Rehab Center # 0050526 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	
1	Totals from Page 12A, Carried Forward		$ 7,347,812	$ 188,406		$ 188,401	$ (5)	$ 806,515	1
2	CONTINUED FROM PREVIOUS PAGE								2
3	4th floor corridor (vinyl floor tile, handrail, paint, corner								3
4	guards), 4th floor lounge (vinyl floor tile, wall base, painting,								4
5	corner guards, window treatments)	12/23/2012	295,793	7,585	39	7,584	(1)	15,170	5
6									6
7	Guages	9/12/2012	1,995	51	39	17	(34)	51	7
8	Carpeting & cove base	6/12/2012	1,521	39	39	23	(16)	39	8
9	Motor	3/20/2012	1,595	41	39	31	(10)	41	9
10	Generator switches	9/20/2013	1,165	30	39	7	(23)	30	10
11	Hydraulic pump	8/31/2013	4,286	110	39	37	(73)	110	11
12	Walk in cooler	9/20/2013	3,850	99	39	25	(74)	99	12
13	New Tile floors	1/11/2013	50,000	1,282	39	1,282		1,282	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	TOTAL (lines 1 thru 33)		$ 7,708,017	$ 197,643		$ 197,407	$ (236)	$ 823,337	34

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

Facility Name & ID Number Central Nrsg & Rehab Center # 0050526 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	$ 1,630,376	$ 230,754	$ 540,359	$ 309,605	5	$ 1,039,826	71
72	Current Year Purchases	46,174	46,174	6,953	(39,221)	5	46,174	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,676,550	$ 276,928	$ 547,312	$ 270,384		$ 1,086,000	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)	$ 9,884,567	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 474,571	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 744,719	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 270,148	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,909,337	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: Central Nrsg & Rehab Center # 0050526 Report Period Beginning: 1/1/13 Ending: 12/31/13

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.	/2014	$
13.	/2015	$
14.	/2016	$

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.

Facility Name & ID Number Central Nrsg & Rehab Center # 0050526 Report Period Beginning: 1/1/13 Ending: 12/31/13

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.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	$		$ 190,533	$		$ 190,533	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			46,107			46,107	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			244,738			244,738	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				112,627		112,627	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): lab, radiology,ambulance						15,019		15,019	13
14	TOTAL			$		$ 481,378	$ 127,646		$ 609,024	14

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

Facility Name & ID Number Central Nrsg & Rehab Center # 0050526 Report Period Beginning: 1/1/13 Ending: 12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/13 (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	$ (132,550)	$ 146,289	1
2	Cash-Patient Deposits	(2,197)	(2,197)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,918,762	2,918,762	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	261,728	261,728	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,045,743	$ 3,324,582	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	725,518	725,518	15
16	Equipment, at Historical Cost	176,550	1,676,550	16
17	Accumulated Depreciation (book methods)	(204,933)	(1,909,337)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		16,254,933	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(4,695,862)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		557,132	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 697,135	$ 20,091,434	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,742,878	$ 23,416,016	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,397,316	$ 1,743,491	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	755,965	755,965	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	609,094	609,094	36
37	working capital	675,000	675,000	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,437,375	$ 3,783,550	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		21,220,905	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)**	$	$ 21,220,905	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,437,375	$ 25,004,455	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 305,503	$ (1,588,439)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,742,878	$ 23,416,016	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (83,218)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (83,218)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,056,308)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Related Party Property Co Net Income**	1,445,029	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 388,721	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)**	$ 305,503	24 *

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

Facility Name & ID Number Central Nrsg & Rehab Center # 0050526 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	$ 10,859,464	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,859,464	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	127,748	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 127,748	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***	4,388	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,388	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Related Party Property Company Income	2,700,000	28
28a	Misc Revenue	(1,458)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,698,542	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,690,142	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,323,556	31
32	Health Care	3,616,885	32
33	General Administration	2,081,003	33
	B. Capital Expense		
34	Ownership	6,767,289	34
	C. Ancillary Expense		
35	Special Cost Centers	127,646	35
36	Provider Participation Fee	588,366	36
	D. Other Expenses (specify):		
37	bad debt	241,705	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,746,450	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,056,308)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,056,308)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 8,723,340	44
45	Private Pay - Net Inpatient Revenue	261,015	45
46	Medicare - Net Inpatient Revenue	1,806,848	46
47	Other-(specify) Commercial Net Inpatient Revenue	68,261	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,859,464	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.

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,888	2,240	$ 112,769	$ 50.34	1
2	Assistant Director of Nursing	1,992	2,200	75,350	34.25	2
3	Registered Nurses	31,084	34,042	952,869	27.99	3
4	Licensed Practical Nurses	23,989	25,883	571,915	22.10	4
5	CNAs & Orderlies	70,737	78,472	851,283	10.85	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	8,955	9,774	127,493	13.04	9
10	Activity Assistants					10
11	Social Service Workers	5,431	5,849	98,369	16.82	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,974	21,975	256,197	11.66	15
16	Dishwashers					16
17	Maintenance Workers	1,432	1,827	22,388	12.25	17
18	Housekeepers	21,108	23,246	261,778	11.26	18
19	Laundry	1,904	2,198	19,989	9.09	19
20	Administrator	2,008	2,160	95,291	44.12	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,735	9,080	94,246	10.38	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	2,080	2,280	30,647	13.44	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	202,317	221,226	$ 3,570,584 *	$ 16.14	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	454	$ 22,685	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	708	35,407	10-3	38
39	Pharmacist Consultant	472	23,607	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	197	9,831	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,831	$ 91,530		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Phillip Morganstern	admin		$ 95,291
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 95,291

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	acctg	$ 8,680
johnson goldberg & brown	acctg	7,000
louis reiff	legal	900
jessee outlaw	legal	960
valee salone	legal	1,000
peck bloom	legal	1,893
stirs	consulting	47,500
infinity	consulting	159,810
infinity funding	consulting	5,001
various	prof fees	124,839
various	legal	28,000
various	consulting	418,749
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 804,332

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 97,082
Unemployment Compensation Insurance	90,457
FICA Taxes	296,007
Employee Health Insurance	180,825
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
pension	11,488
employee exp	12,900
uniforms	7,346
TOTAL (agree to Schedule V, line 22, col.8)	$ 696,105

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks	
illinois council	22,935
city of chicago	500
infinity	387
sec of state	500
other expenses	3,245
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 31,547

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
auto allowance	8,043
mileage	329
Seminar Expense	
seminar	955
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,327

**See instructions.

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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
					Amount of Expense Amortized Per Year								
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	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		$		$	$	$	$	$	$	$	$	$

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. $ **32,863** 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. $ **241,705**
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. $ **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? **0**
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 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.