

		FOR OHF USE					

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**2005**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2005)**

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.

<p><b>I. IDPH Facility ID Number:</b> <u>0045450</u></p> <p><b>Facility Name:</b> <u>HAMPTON PLAZA NURSING &amp; REHAB CENTER</u></p> <p><b>Address:</b> <u>9777 N. GREENWOOD</u> <u>NILES</u> <u>60714</u>          Number City Zip Code</p> <p><b>County:</b> <u>COOK</u></p> <p><b>Telephone Number:</b> <u>( 847 ) 470-0000</u> Fax # <u>( 847 ) 967-5462</u></p> <p><b>IDPA ID Number:</b> <u>36-4426497</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>06/01/2001</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>BOB KAGDA</u> <b>Telephone Number:</b> <u>( 847 ) 675-3585</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2005</u> to <u>12/31/2005</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>ELI ATKIN</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>MEMBER</u></td> <td></td> </tr> <tr> <td rowspan="4" style="width: 15%;"><b>Paid Preparer</b></td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u></td> <td></td> </tr> <tr> <td>(Firm Name &amp; Address) <u>KRUPNICK, BOKOR, KAGDA &amp; BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>( 847 ) 675-3585</u> Fax # <u>( 847 ) 675-5777</u></td> <td></td> </tr> </table> <p align="right">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</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____	(Type or Print Name) <u>ELI ATKIN</u>			(Title) <u>MEMBER</u>		<b>Paid Preparer</b>	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u>		(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA &amp; BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>		(Telephone) <u>( 847 ) 675-3585</u> Fax # <u>( 847 ) 675-5777</u>	
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Facility Name & ID Number HAMPTON PLAZA NURSING & REHAB CENTER

# 0045450 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	152	Skilled (SNF)	152	55,480	1
2		Skilled Pediatric (SNF/PED)			2
3	152	Intermediate (ICF)	152	55,480	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	304	TOTALS	304	110,960	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	25,387	2,094	8,328	35,809	8	
9	SNF/PED					9	
10	ICF					10	
11	ICF/DD	53,946	2,775	1,819	58,540	11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	79,333	4,869	10,147	94,349	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.03%

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

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

I. On what date did you start providing long term care at this location?  
Date started 06/01/01

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 06/01/01 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 152 and days of care provided 8,328

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

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

Facility Name & ID Number HAMPTON PLAZA NURSING & REHAB C # 0045450 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	548,083	79,109	1,423	628,615		628,615		628,615		1
2	Food Purchase		493,485		493,485	(35,259)	458,226	(1,831)	456,395		2
3	Housekeeping	375,459	53,343		428,802		428,802		428,802		3
4	Laundry	98,614	34,237		132,851		132,851		132,851		4
5	Heat and Other Utilities			300,733	300,733		300,733		300,733		5
6	Maintenance	106,441	30,377	88,097	224,915		224,915	667	225,582		6
7	Other (specify):*			30,872	30,872		30,872		30,872		7
8	<b>TOTAL General Services</b>	1,128,597	690,551	421,125	2,240,273	(35,259)	2,205,014	(1,164)	2,203,850		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			21,000	21,000		21,000		21,000		9
10	Nursing and Medical Records	3,947,982	169,182	23,898	4,141,062		4,141,062		4,141,062		10
10a	Therapy	300,811	676	10,718	312,205		312,205		312,205		10a
11	Activities	235,775	33,495		269,270		269,270		269,270		11
12	Social Services	141,881			141,881		141,881		141,881		12
13	CNA Training										13
14	Program Transportation			3,020	3,020		3,020		3,020		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	4,626,449	203,353	58,636	4,888,438		4,888,438		4,888,438		16
	<b>C. General Administration</b>										
17	Administrative	48,278		496,500	544,778		544,778	157,876	702,654		17
18	Directors Fees										18
19	Professional Services			119,696	119,696		119,696	5,880	125,576		19
20	Dues, Fees, Subscriptions & Promotions			103,714	103,714		103,714	(78,442)	25,272		20
21	Clerical & General Office Expenses	105,102	41,274	405,018	551,394		551,394	(197,482)	353,912		21
22	Employee Benefits & Payroll Taxes			765,196	765,196	35,259	800,455		800,455		22
23	Inservice Training & Education			5,748	5,748		5,748		5,748		23
24	Travel and Seminar			140	140		140		140		24
25	Other Admin. Staff Transportation			8,314	8,314		8,314	(4,242)	4,072		25
26	Insurance-Prop.Liab.Malpractice			257,992	257,992		257,992		257,992		26
27	Other (specify):*							82,737	82,737		27
28	<b>TOTAL General Administration</b>	153,380	41,274	2,162,318	2,356,972	35,259	2,392,231	(33,673)	2,358,558		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	5,908,426	935,178	2,642,079	9,485,683		9,485,683	(34,837)	9,450,846		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 PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	<b>DIETARY</b>		
	DIETITIAN CONSULTANT	XVIII B 35-2	0
	REPAIRS & MAINTENANCE		1,423
			0
			1,423
3	<b>HOUSEKEEPING</b>		
			0
			0
			0
4	<b>LAUNDRY</b>		
	EQUIPMENT REPAIRS & MAINTENANCE		0
			0
			0
5	<b>HEAT &amp; OTHER UTILITIES</b>		
	GAS HEAT		130,243
	ELECTRICITY		110,783
	WATER		58,853
	CABLE TV - LOBBY		854
			0
			300,733
6	<b>MAINTENANCE</b>		
	GROUNDS MAINTENANCE		12,930
	PAINTING & DECORATING		438
	BUILDING REPAIRS		9,255
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		44,713
	ELEVATOR MAINTENANCE & REPAIR		15,176
	OUTSIDE LABOR		0
	EXTERMINATING SERVICE		5,225
	FIRE SERVICE		360
			0
			0
			0
			88,097
7	<b>OTHER</b>		
	SCAVENGER		30,872
	SECURITY SERVICE		0
			30,872
9	<b>MEDICAL DIRECTOR</b>		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	21,000
			21,000

LINE		SCHED REF	TOTAL
10	<b>NURSING</b>		
	CONTRACT NURSING	XVIII C 53-2	
	LABORATORY & XRAY EXPENSE		16,035
	PURCHASED SERVICES		0
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0
	PHARMACY CONSULTANT	XVIII B 39-2	7,651
	UTILIZATION REVIEW FEES	XVIII B __-2	0
	PHYSICIANS	XVIII B __-2	212
	PSYCHIATRIC	XVIII B __-2	0
	RN CONSULTANT	XVIII B 38-2	0
			0
			0
			23,898
10a	<b>THERAPY</b>		
	PHYSICAL THERAPY SERVICES		
	SPEECH THERAPY SERVICES		0
	OCCUPATIONAL THERAPY SERVICES		0
	REHABILITATION CONSULTANT	XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	336
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	6,930
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	3,452
			10,718
11	<b>ACTIVITIES</b>		
	CABLE TV - PATIENT ROOMS		0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0
			0
			0
12	<b>SOCIAL SERVICES</b>		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0
	SOCIAL WORKER	XVIII B 45-2	0
			0
			0
13	<b>NURSE AIDE TRAINING</b>		
	NURSE AIDE TRAINING COSTS	XIII	0
			0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>14</b>	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	3,020
<b>17</b>	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	496,500
<b>18</b>	<b>DIRECTORS FEES</b>	0
<b>19</b>	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	13,729
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	105,967
		0
		119,696
<b>20</b>	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	45,534
	EMPLOYEE WANT ADS XIX F	15,431
	CONTRIBUTIONS VI 20 XIX F	5,448
	DUES & SUBSCRIPTIONS XIX F	1,859
	LICENSES & PERMITS XIX F	7,546
	PUBLIC RELATIONS-PATIENT RELATED XIX F	27,460
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	436
		103,714
<b>21</b>	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	76,801
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	268,200
	PENALTIES / OVERDRAFT CHARGES VI 18	5,987
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	49,028
	MESSENGER SERVICE	5,002
		0
		405,018

LINE	SCHED REF	TOTAL
<b>22</b>	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	447,759
	UNEMPLOYMENT COMPENSATION XIX D	87,491
	WORKERS COMPENSATION INSURANCE XIX D	92,992
	HOSPITALIZATION INSURANCE XIX D	92,398
	EMPLOYEE BENEFITS - OTHER XIX D	44,556
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		765,196
<b>23</b>	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	5,748
		5,748
<b>24</b>	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	140
		0
		0
		140
<b>25</b>	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	8,314
		8,314
<b>26</b>	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	257,992
		257,992
<b>27</b>	<b>OTHER</b>	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

2,642,079

HAMPTON PLAZA NURSING & REHAB CENTER  
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)  
 12/31/2005

TOTAL FOOD PURCHASE	493,485	PATIENT MEALS	283047
LESS SALES TAX	(1,831)	ADD EMPLOYEE MEALS	21900
	-----		-----
NET FOOD	491,654	TOTAL MEALS/YEAR	304947
TOTAL PATIENT CENSUS	94,349	NET FOOD	491654
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	304947
	-----		
TOTAL PATIENT MEALS	283047	COST PER MEAL	1.61
		TIME EMPLOYEE MEALS	21900
ADD # EMPLOYEE MEALS/DAY	60		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	35259
	-----		=====
TOTAL EMPLOYEE MEALS	21900		

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			20,037	20,037		20,037	7,528	27,565		30
31	Amortization of Pre-Op. & Org.			7,111	7,111		7,111		7,111		31
32	Interest			166,656	166,656		166,656	(16,671)	149,985		32
33	Real Estate Taxes			507,248	507,248		507,248		507,248		33
34	Rent-Facility & Grounds			2,022,780	2,022,780		2,022,780		2,022,780		34
35	Rent-Equipment & Vehicles			52,272	52,272		52,272		52,272		35
36	Other (specify):* SECTION 754			2,545	2,545		2,545		2,545		36
37	<b>TOTAL Ownership</b>			2,778,649	2,778,649		2,778,649	(9,143)	2,769,506		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		245,392	982	246,374		246,374		246,374		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			166,440	166,440		166,440		166,440		42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>		245,392	167,422	412,814		412,814		412,814		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,908,426	1,180,570	5,588,150	12,677,146		12,677,146	(43,980)	12,633,166		45

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

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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	7,528	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,831)	2		13
14	Non-Care Related Interest	(16,671)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(5,987)	21		18
19	Entertainment		20		19
20	Contributions	(5,448)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(72,994)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(80,476)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (175,879)		\$	30

OHF 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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	131,899		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 131,899		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (43,980)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

**C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)**

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.		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	Exceptional Care Program		X		44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

STATE OF ILLINOIS  
 HAMPTON PLAZA NURSING & REHAB CENTER

ID# 0045450

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 667	6	1
2	BANK CHARGE	(76,801)	21	2
3				3
4	LEGAL FEES	(100)	19	4
5	MARKETING TRAVEL	(4,242)	25	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	<b>Total</b>	(80,476)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number HAMPTON PLAZA NURSING & REHAB CENTER# 0045450

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

## 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)	
<b>1</b>	<b>A. General Services</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,831)	0	0	0	0	0	0	0	0	0	0	(1,831)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	667	0	0	0	0	0	0	0	0	0	0	667	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(1,164)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,164)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	157,876	0	0	0	0	0	0	0	0	0	157,876	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(100)	5,980	0	0	0	0	0	0	0	0	0	5,880	19
20	Fees, Subscriptions & Promotions	(78,442)	0	0	0	0	0	0	0	0	0	0	(78,442)	20
21	Clerical & General Office Expenses	(82,788)	(114,694)	0	0	0	0	0	0	0	0	0	(197,482)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(4,242)	0	0	0	0	0	0	0	0	0	0	(4,242)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	82,737	0	0	0	0	0	0	0	0	0	82,737	27
28	<b>TOTAL General Administration</b>	<b>(165,572)</b>	<b>131,899</b>	<b>0</b>	<b>(33,673)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(166,736)</b>	<b>131,899</b>	<b>0</b>	<b>(34,837)</b>	<b>29</b>								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number HAMPTON PLAZA NURSING & REHAB CENTER # 0045450 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	7,528	0	0	0	0	0	0	0	0	0	0	7,528	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(16,671)	0	0	0	0	0	0	0	0	0	0	(16,671)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	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	<b>TOTAL Ownership</b>	<b>(9,143)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(9,143)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(175,879)</b>	<b>131,899</b>	<b>0</b>	<b>(43,980)</b>	<b>45</b>								



Facility Name & ID Number HAMPTON PLAZA NURSING & REHAB # 0045450 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ELI ATKIN		ADMIN.,PURCH.,		LEAF MANMNT			mngmnt fees	\$ 165,000	17-3	1
2			BANKING		SALARY= \$50,224			SALARY	30,647	17-7	2
3	NOAH WOLFE		ADMIN.					mngmnt fees	101,000	17-3	3
4											4
5	HELEN LACEK	MEMBER	ADMIN.	1.64	LEAF MANMNT			mngmnt fees	5,500	17-3	5
6					SALARY= \$106,250			SALARY	64,835	17-7	6
7	DONNA ATKIN	MEMBER	ADMIN.	18.86				mngmnt fees	30,000	17-3	7
8											8
9	JOEL ATKIN	MEMBER	ADMIN.	19.71				mngmnt fees	195,000	17-3	9
10											10
11	JAY ORLINSKY	CFO	BANKING, A/R,		LEAF MANMNT			SALARY	62,394	17-7	11
12			A/P, ADMIN.		SALARY= \$102,250						12
13								TOTAL	\$ 654,376		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 HAMPTON PLAZA NURSING & REHAB CENTER # 0045450 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization LEAF MANAGEMENT  
 Street Address 9777 W. GREENWOOD  
 City / State / Zip Code NILES, IL 60714-1002  
 Phone Number ( 847 ) 470-0000  
 Fax Number ( 847 ) 470-0061

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
1	17	OFFICER SALARY	PATIENT DAYS	154,617	4	\$ 50,224	\$ 50,224	94,349	\$ 30,647	1
2	17	ADMIN SALARY-ORLINSKY	PATIENT DAYS	154,617	4	102,250	102,250	94,349	62,394	2
3	17	ADMIN SALARY-LACEK	PATIENT DAYS	154,617	4	106,250	106,250	94,349	64,835	3
4	19	ACCOUNTING FEES	PATIENT DAYS	154,617	4	9,800		94,349	5,980	4
5	21	OFFICE EXPENSE	PATIENT DAYS	154,617	4	11,333		94,349	6,916	5
6	21	CLERICAL SALARIES	PATIENT DAYS	154,617	4	240,228	240,228	94,349	146,590	6
7	27	PAY.TAXES & HEALTH INS.	PATIENT DAYS	154,617	4	135,588		94,349	82,737	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					\$ 655,673	\$ 498,952		\$ 400,099	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	
										Reporting Period Interest Expense
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			
<b>A. Directly Facility Related</b>										
<b>Long-Term</b>										
1						\$	\$			\$
2										
3										
4	IST BANK	X	WORKING CAPITAL	\$6,098.00	04/18/01		308,228		0.0700	16,867
5	MB	X	WORKING CAPITAL	INT + \$25,000	08/11/08	300,000	200,000			7,827
<b>Working Capital</b>										
6	CIB	X	WORKING CAPITAL		06/01/01	500,000			prime +	3,714
7	ALBANY BANK	x	WORKING CAPITAL	INT ONLY	06/01/01	1,750,000				304
8	MB	X	WORKING CAPITAL	INT ONLY	01/07/05	1,759,613	2,000,000		prime +	121,273
9	<b>TOTAL Facility Related</b>			\$6,098.00		\$ 4,309,613	\$ 2,508,228			\$ 149,985
<b>B. Non-Facility Related*</b>										
10	IRS, IDR, ETC	X	LATE FEES							25
11	BED TAX									16,646
12										
13										
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$ 16,671
15	<b>TOTALS (line 9+line14)</b>					\$ 4,309,613	\$ 2,508,228			\$ 166,656

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

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

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

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

**B. Real Estate Taxes**

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

1. Real Estate Tax accrual used on 2004 report.		\$	<b>456,292</b>	<b>1</b>
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<b>481,770</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>25,478</b>	<b>3</b>
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>481,770</b>	<b>4</b>
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>507,248</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	<b>2000</b>	<b>455,051</b>	<b>8</b>
	<b>2001</b>	<b>440,501</b>	<b>9</b>
	<b>2002</b>	<b>457,541</b>	<b>10</b>
	<b>2003</b>	<b>456,292</b>	<b>11</b>
	<b>2004</b>	<b>481,770</b>	<b>12</b>

**THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL**

**THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.**

<b>FOR OHF USE ONLY</b>			
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2004	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**NOTES:**

- Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
- 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.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2004 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME HAMPTON PLAZA NURSING & REHAB CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0045450

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE ( 847 ) 675-3585 FAX #: ( 847 ) 675-5777

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

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>09-11-306-005-0000</u>	<u>NURSING HOME</u>	\$ <u>190,866.38</u>	\$ <u>190,866.38</u>
2. <u>09-11-306-006-0000</u>	<u>NURSING HOME</u>	\$ <u>190,785.42</u>	\$ <u>190,785.42</u>
3. <u>09-11-306-013-0000</u>	<u>NURSING HOME</u>	\$ <u>100,118.18</u>	\$ <u>100,118.18</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>481,769.98</u>	\$ <u>481,769.98</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES        X        NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: \_\_\_\_\_ B. General Construction Type: Exterior \_\_\_\_\_ Frame \_\_\_\_\_ Number of Stories \_\_\_\_\_

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

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

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

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

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

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

**XI. OWNERSHIP COSTS:**

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

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	COMPRESSOR		2001	25,197	916	27.5	916		4,008	9
10	ELECTRICAL WIRING		2002	3,064	111	27.5	111		393	10
11	CLOSED CIRCUIT TV SYSTEM		2002	10,622	388	27.5	388		1,280	11
12	REPIPE LEAKING CONDENSOR		2002	2,994	107	27.5	107		473	12
13	SPRAY MISTER SYSTEM		2002	11,932	434	27.5	434		1,537	13
14	NEW GATE KEEPER		2002	3,710	135	27.5	135		478	14
15	CEILING TILE		2002	1,749	64	27.5	64		227	15
16	CARPETING		2002	21,788	1,757	5	4,358	2,601	15,253	16
17	PAINTING & WALLPAPER		2003	7,235	972	5	1,447	475	3,618	17
18	CAPETING		2003	17,812	2,394	5	3,562	1,168	8,905	18
19	WALL BASE & COVE		2003	936	126	5	187	61	468	19
20	HOUSE PUMP		2004	4,577	167	27.5	167		257	20
21	EXHAUST FOR SMOKING ROOM		2004	3,465	126	27.5	126		194	21
22	WET CHEMICAL FIRE SYSTEM		2004	3,200	116	27.5	116		179	22
23	AIR CONDITIONING COMPRESSORS		2004	21,500	782	27.5	782		1,206	23
24	STELL PEDESTRIAN DOOR		2005	1,965	39	27.5	39		39	24
25	A/C COMPRESSOR		2005	12,625	249	27.5	249		249	25
26	FOORING		2005	8,422	166	27.5	166		166	26
27	CONTROL PANEL FOR NURSE CALL SYSTEM		2005	2,213	43	27.5	43		43	27
28	CAPETING		2005	24,738	1,237	5	4,948	3,711	4,948	28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

**XI. OWNERSHIP COSTS (continued)**

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									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	<b>TOTAL (lines 4 thru 69)</b>		\$ <b>189,744</b>	\$ <b>10,329</b>		\$ <b>18,345</b>	\$ <b>8,016</b>	\$ <b>43,921</b>	<b>70</b>

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 86,824	\$ 9,171	\$ 8,683	\$ (488)	10 YRS	\$ 28,732	71
72	Current Year Purchases	10,734	537	537		10 YRS	537	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 97,558	\$ 9,708	\$ 9,220	\$ (488)		\$ 29,269	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 287,302	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 20,037	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 27,565	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 7,528	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 73,190	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: HAMPTON PLAZA HEALTHCARE CENTER REAL ESTATE LIMITED PARTNERSHIP

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

If NO, see instructions.  YES  NO

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>304</u>	<u>06/01/01</u>	\$ <u>2,022,780</u>			3
4	Additions						4
5							5
6							6
7	<b>TOTAL</b>	<b>304</b>		\$ <b>2,022,780</b>			<b>7</b>

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
 by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 45,373 Description: SEE SCHEDULE ATTACHED

(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	<u>patient trasportation</u>	<u>FORD E350 2003</u>	\$ <u>575.00</u>	\$ <u>6,899</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ <b>575.00</b>	\$ <b>6,899</b>	<b>21</b>

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. 5/31/2006 \$ 2,002,448

13. 5/31/2007 \$ 2,002,448

14. 5/31/2008 \$ 2,002,448

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$				1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescripts				227,910		227,910	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	39-8				982	17,482		18,464	13
14	<b>TOTAL</b>			\$		\$ 982	\$ 245,392		\$ 246,374	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 &amp; ID Number HAMPTON PLAZA NURSING &amp; REHAB CENTER

# 0045450

Report Period Beginning: 01/01/2005

Ending:

12/31/2005

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2005

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 45,285	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	3,040,566		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	333,345		6
7	Other Prepaid Expenses	4,711		7
8	Accounts Receivable (owners or related parties)	3,103,223		8
9	Other(specify): <u>EMPLOYEE LOANS</u>	178		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 6,527,308	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	117,235		15
16	Equipment, at Historical Cost	170,067		16
17	Accumulated Depreciation (book methods)	(138,664)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	35,556		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(32,592)		20
21	Restricted Funds			21
22	Other Long-Term Assets (spec <u>comp. software</u> )	11,170		22
23	Other(specify): <u>synd.fee/section 754</u>	227,498		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 390,270	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 6,917,578	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,811,022	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	246,354		30
31	Accrued Taxes Payable (excluding real estate taxes)	76,779		31
32	Accrued Real Estate Taxes(Sch.IX-B)	481,770		32
33	Accrued Interest Payable	15,714		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>NOTE PAYABLE-MB &amp; 1ST. BANK</u>	2,508,228		36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 5,139,867	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 5,139,867	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 1,777,711	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 6,917,578	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>752,041</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>POST CLOSING ADJ</b>	<b>24,235</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>776,276</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>1,001,435</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>1,001,435</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,777,711</b>	<b>24</b> *

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

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

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

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 13,413,051	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 13,413,051	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	252,309	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 252,309	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	22	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 22	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>VENDING COMMISSIONS</b>	880	28
28a	<b>ADJ PRIOR YEAR EXPENSE</b>	12,319	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 13,199	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 13,678,581	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	2,240,273	31
32	Health Care	4,888,438	32
33	General Administration	2,356,972	33
	<b>B. Capital Expense</b>		
34	Ownership	2,778,649	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	246,374	35
36	Provider Participation Fee	166,440	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 12,677,146	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,001,435	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,001,435	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

TAX RETURN NOT COMPLETED AS OF COST REPORT FILING DATE

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

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

Facility Name & ID Number **HAMPTON PLAZA NURSING & REHAB CENTER**

# **0045450**

Report Period Beginning: **01/01/2005**

Ending:

**12/31/2005**

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,080	2,080	\$ 75,184	\$ 36.15	1
2	Assistant Director of Nursing	1,762	2,251	64,438	28.63	2
3	Registered Nurses	45,744	49,333	1,367,628	27.72	3
4	Licensed Practical Nurses	19,778	20,798	499,208	24.00	4
5	CNAs & Orderlies	137,581	147,890	1,743,732	11.79	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,750	11,468	300,811	26.23	8
9	Activity Director	1,887	2,068	37,321	18.05	9
10	Activity Assistants	19,104	20,238	198,454	9.81	10
11	Social Service Workers	10,504	11,216	141,881	12.65	11
12	Dietician					12
13	Food Service Supervisor	2,857	3,135	46,358	14.79	13
14	Head Cook	2,257	2,486	29,906	12.03	14
15	Cook Helpers/Assistants	47,499	51,326	471,819	9.19	15
16	Dishwashers					16
17	Maintenance Workers	6,447	6,911	106,441	15.40	17
18	Housekeepers	36,955	40,871	375,459	9.19	18
19	Laundry	8,393	9,541	98,614	10.34	19
20	Administrator	1,937	2,086	48,278	23.14	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,472	6,018	64,361	10.69	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	3,545	3,875	49,848	12.86	31
32	Other Health Care(specify)	2,413	2,498	55,700	22.30	32
33	Other(specify) <u>ward clerk/admit</u>	9,173	9,889	132,985	13.45	33
34	TOTAL (lines 1 - 33)	376,138	405,978	\$ 5,908,426 *	\$ 14.55	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	\$ 0	1-3	35
36	Medical Director	Monthly Fee 21,000	9-3	36
37	Medical Records Consultant	0	10-3	37
38	Nurse Consultant	0	10-3	38
39	Pharmacist Consultant	Monthly Fee 7,651	10-3	39
40	Physical Therapy Consultant	0	10a-3	40
41	Occupational Therapy Consultant	Monthly Fee 336	10a-3	41
42	Respiratory Therapy Consultant	Monthly Fee 6,930	10a-3	42
43	Speech Therapy Consultant	Monthly Fee 3,452	10a-3	43
44	Activity Consultant	0	11-3	44
45	Social Service Consultant	0	12-3	45
46	Other(specify) <u>PHYSICIANS</u>	Monthly Fee 212	10-3	46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 39,581		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ 0	10-3	50
51	Licensed Practical Nurses	0	10-3	51
52	Certified Nurse Assistants/Aides	0	10-3	52
53	TOTAL (lines 50 - 52)	\$		53

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
JAMIE FENTON	ADMIN		\$ 48,278	Workers' Compensation Insurance	\$ 92,992	IDPH License Fee	\$ 1,990	
	ASST ADMIN		0	Unemployment Compensation Insurance	87,491	Advertising: Employee Recruitment	15,431	
				FICA Taxes	447,759	Health Care Worker Background Check	436	
				Employee Health Insurance	92,398	(Indicate # of checks performed )		
				Employee Meals	35,259	MARKETING/ADV/PROMO	72,994	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	5,448	
				EMPLOYEE BENEFITS - OTHER	44,556	LICENSES & PERMITS	5,556	
				EMPLOYEE PHYSICAL EXAMS	0	DUES & SUBSCRIPTIONS	1,859	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOCATION		
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(5,448)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(27,460)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(45,534)	
						Yellow page advertising	( 0 )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 48,278	TOTAL (agree to Schedule V, line 22, col.8)	\$ 800,455	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 25,272	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
SEE SCHEDULE ATTACHED			\$ 496,500			\$	Out-of-State Travel	\$
							In-State Travel	140
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 496,500				Seminar Expense	0
C. Professional Services							Entertainment Expense	( )
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)	
			\$				TOTAL	\$ 140
SEE SCHEDULE ATTACHED			119,696	TOTAL		\$		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 119,696					

\* Attach copy of IMRF notifications

\*\*See instructions.

**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								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	<b>PAINT/DECORATING</b>	<b>2002</b>	<b>\$ 4,000</b>	<b>3 YRS</b>	<b>\$ 667</b>	<b>\$ 1,333</b>	<b>\$ 1,333</b>	<b>\$ 667</b>					
2													
3													
4													
5													
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16													
17													
18													
19													
20	<b>TOTALS</b>		<b>\$ 4,000</b>		<b>\$ 667</b>	<b>\$ 1,333</b>	<b>\$ 1,333</b>	<b>\$ 667</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>

Facility Name & ID Number HAMPTON PLAZA NURSING & REHAB CENTER# 0045450Report Period Beginning: 01/01/2005Ending: 12/31/2005**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. IL ASSO.OF HEALTHCARE \$3507.50
- (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? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 166,440  
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. \$ 35,259 Has any meal income been offset against related costs? \_\_\_\_\_ Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 5%  
d. Have vehicle usage logs been maintained? NO  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
g. **Does the facility transport residents to and from day training? NO**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (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 \$2500, 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