

Facility Name & ID Number HAMPTON PLAZA NURSING & REHAB CENTER

0045450 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	26,839	1,067	7,238	35,144	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	57,033	1,156	1,297	59,486	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	83,872	2,223	8,535	94,630	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.28%

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 7,238

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number **HAMPTON PLAZA NURSING & REHAB C** # **0045450** Report Period Beginning: **01/01/2006** Ending: **12/31/2006**

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
	A. General Services										
1	Dietary	569,182	55,762	0	624,944		624,944	0	624,944		1
2	Food Purchase		507,140		507,140	(36,135)	471,005	(1,737)	469,268		2
3	Housekeeping	387,610	51,638	0	439,248		439,248	0	439,248		3
4	Laundry	102,752	60,701	0	163,453	0	163,453	0	163,453		4
5	Heat and Other Utilities			240,084	240,084		240,084	0	240,084		5
6	Maintenance	148,926	25,992	108,482	283,400		283,400	0	283,400		6
7	Other (specify):*			33,366	33,366		33,366	0	33,366		7
8	TOTAL General Services	1,208,470	701,233	381,932	2,291,635	(36,135)	2,255,500	(1,737)	2,253,763		8
	B. Health Care and Programs										
9	Medical Director	0		43,000	43,000		43,000	0	43,000		9
10	Nursing and Medical Records	4,456,002	112,324	12,875	4,581,201		4,581,201	0	4,581,201		10
10a	Therapy	490,819	2,107	15,640	508,566		508,566	0	508,566		10a
11	Activities	248,703	29,525	0	278,228		278,228	0	278,228		11
12	Social Services	120,093		0	120,093		120,093	0	120,093		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			1,247	1,247		1,247	0	1,247		14
15	Other (specify):*			0	0		0	0	0		15
16	TOTAL Health Care and Programs	5,315,617	143,956	72,762	5,532,335	0	5,532,335	0	5,532,335		16
	C. General Administration										
17	Administrative	64,010		419,000	483,010		483,010	193,885	676,895		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			78,294	78,294		78,294	(8,288)	70,006		19
20	Dues, Fees, Subscriptions & Promotions			114,754	114,754		114,754	(76,148)	38,606		20
21	Clerical & General Office Expenses	140,843	49,028	508,226	698,097		698,097	(398,382)	299,715		21
22	Employee Benefits & Payroll Taxes			916,744	916,744	36,135	952,879	0	952,879		22
23	Inservice Training & Education			0	0		0	0	0		23
24	Travel and Seminar			11,229	11,229		11,229	0	11,229		24
25	Other Admin. Staff Transportation			16,478	16,478		16,478	(6,281)	10,197		25
26	Insurance-Prop.Liab.Malpractice			284,651	284,651		284,651	0	284,651		26
27	Other (specify):*			0	0		0	116,156	116,156		27
28	TOTAL General Administration	204,853	49,028	2,349,376	2,603,257	36,135	2,639,392	(179,058)	2,460,334		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,728,940	894,217	2,804,070	10,427,227	0	10,427,227	(180,795)	10,246,432		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	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	0
	REPAIRS & MAINTENANCE	0
		0
3	HOUSEKEEPING	
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	74,877
	ELECTRICITY	106,545
	WATER	56,438
	CABLE TV - LOBBY	2,224
		0
		240,084
6	MAINTENANCE	
	GROUNDS MAINTENANCE	5,800
	PAINTING & DECORATING	81
	BUILDING REPAIRS	17,398
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	56,083
	ELEVATOR MAINTENANCE & REPAIR	24,737
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	4,020
	FIRE SERVICE	363
		0
		0
		0
		0
		108,482
7	OTHER	
	SCAVENGER	33,366
	SECURITY SERVICE	0
		0
		0
		33,366
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	43,000
		43,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	9,627
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	300
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	2,948
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		12,875
10a	THERAPY	
	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 CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	15,640
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		15,640
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
		0
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	1,247
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	419,000
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	19,561
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	58,733
		0
		78,294
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	31,459
	EMPLOYEE WANT ADS XIX F	6,576
	CONTRIBUTIONS VI 20 XIX F	1,850
	DUES & SUBSCRIPTIONS XIX F	17,159
	LICENSES & PERMITS XIX F	5,851
	PUBLIC RELATIONS-PATIENT RELATED XIX F	42,839
	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	9,020
	PATIENT BACKGROUND CHECKS XIX F	0
		114,754
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	98,939
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	368,200
	PENALTIES / OVERDRAFT CHARGES VI 18	8,531
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	26,144
	MESSENGER SERVICE	6,412
		0
		508,226

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	510,395
	UNEMPLOYMENT COMPENSATION XIX D	79,924
	WORKERS COMPENSATION INSURANC XIX D	109,280
	HOSPITALIZATION INSURANCE XIX D	158,457
	EMPLOYEE BENEFITS - OTHER XIX D	557
	EMPLOYEE PHYSICAL EXAMS XIX D	1,996
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	56,135
	CHICAGO HEAD TAX XIX D	0
		0
		916,744
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	11,229
	TRAVEL XIX G	0
		11,229
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	16,478
		16,478
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	284,651
		284,651
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

2,804,070

HAMPTON PLAZA NURSING & REHAB CENTER
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2006

TOTAL FOOD PURCHASE	507,140	PATIENT MEALS	283890
LESS SALES TAX	(1,737)	ADD EMPLOYEE MEALS	21900
	-----		-----
NET FOOD	505,403	TOTAL MEALS/YEAR	305790
TOTAL PATIENT CENSUS	94,630	NET FOOD	505403
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	305790

TOTAL PATIENT MEALS	283890	COST PER MEAL	1.65
		TIME EMPLOYEE MEALS	21900
ADD # EMPLOYEE MEALS/DAY	60		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	36135
	-----		=====
TOTAL EMPLOYEE MEALS	21900		

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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
	D. Ownership										
30	Depreciation			31,461	31,461		31,461	(1,550)	29,911		30
31	Amortization of Pre-Op. & Org.			2,964	2,964		2,964	0	2,964		31
32	Interest			229,284	229,284		229,284	(16,646)	212,638		32
33	Real Estate Taxes			510,276	510,276		510,276	0	510,276		33
34	Rent-Facility & Grounds			1,997,280	1,997,280		1,997,280	0	1,997,280		34
35	Rent-Equipment & Vehicles			92,215	92,215		92,215	0	92,215		35
36	Other (specify):* SECTION 754			2,545	2,545		2,545	0	2,545		36
37	TOTAL Ownership			2,866,025	2,866,025	0	2,866,025	(18,196)	2,847,829		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation				0		0	0	0		38
39	Ancillary Service Centers		165,048	22,243	187,291		187,291	4,792	192,083		39
40	Barber and Beauty Shops				0		0	0	0		40
41	Coffee and Gift Shops				0		0	0	0		41
42	Provider Participation Fee			166,440	166,440		166,440	0	166,440		42
43	Other (specify):*				0		0	0	0		43
44	TOTAL Special Cost Centers	0	165,048	188,683	353,731	0	353,731	4,792	358,523		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,728,940	1,059,265	5,858,778	13,646,983	0	13,646,983	(194,199)	13,452,784		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	(1,550)	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	(1,737)	2		13
14	Non-Care Related Interest	(16,646)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(8,531)	21		18
19	Entertainment	0	20		19
20	Contributions	(1,850)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(14,582)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(74,298)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule	(163,238)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (282,432)		\$ 0	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	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)	88,233		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 88,233		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (194,199)		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	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS
 HAMPTON PLAZA NURSING & REHAB CENTER

ID# 0045450

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 0	6	1
2	BANK CHARGE	(98,939)	21	2
3	MARKETING SALARYS	(33,018)	21	3
4	MARKETIN SALARY-DONNA ATKIN	(25,000)	21	4
5	NON ALLOWABLE TRAVEL	(6,281)	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	Total	(163,238)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,737)	0	0	0	0	0	0	0	0	0	0	(1,737)	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	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,737)	0	0	0	0	0	0	0	0	0	0	(1,737)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	193,885	0	0	0	0	0	0	0	0	0	193,885	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(14,582)	6,294	0	0	0	0	0	0	0	0	0	(8,288)	19
20	Fees, Subscriptions & Promotions	(76,148)	0	0	0	0	0	0	0	0	0	0	(76,148)	20
21	Clerical & General Office Expenses	(165,488)	(232,894)	0	0	0	0	0	0	0	0	0	(398,382)	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	(6,281)	0	0	0	0	0	0	0	0	0	0	(6,281)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	116,156	0	0	0	0	0	0	0	0	0	116,156	27
28	TOTAL General Administration	(262,499)	83,441	0	(179,058)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(264,236)	83,441	0	(180,795)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number HAMPTON PLAZA NURSING & REHAB CENTER # 0045450 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	(1,550)	0	0	0	0	0	0	0	0	0	0	(1,550) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(16,646)	0	0	0	0	0	0	0	0	0	0	(16,646) 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	TOTAL Ownership	(18,196)	0	0	0	0	0	0	0	0	0	0	(18,196) 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	4,792	0	0	0	0	0	0	0	0	0	4,792 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Centers	0	4,792	0	4,792 44								
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(282,432)	88,233	0	(194,199) 45								

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				INNOVATIVE	NILES	MNGMNT
				HEALTHCARE		
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE				

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	21 OUTSIDE CLERICAL	\$ 368,200	INNOVATIVE HEALTHCARE		\$	\$ (368,200)	1
2	V	39 THERAPY COSTS	16,273				(16,273)	2
3	V	17 OFFICER SAL.-ELI ATKIN				27,627	27,627	3
4	V	17 OFFICER SAL.-JOEL ATKIN				21,610	21,610	4
5	V	17 ADMIN SAL.-ORLINSKY				66,252	66,252	5
6	V	17 ADMIN SAL.-LACEK				78,396	78,396	6
7	V	19 ACCOUNTING, DATA PROC.				6,294	6,294	7
8	V	21 OFFICE EXPENSE				15,961	15,961	8
9	V	21 CLERICAL SALARIES				119,345	119,345	9
10	V	27 PAY.TAXES & HEALTH INS				116,156	116,156	10
11	V	39 THERAPY SALARIES				21,065	21,065	11
12	V							12
13	V							13
14	Total		\$ 384,473			\$ 472,706	\$ *	88,233 14

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

Facility Name & ID Number HAMPTON PLAZA NURSING & REHAB # 0045450 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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		INNOVATIVE MGT			SALARY	\$ 27,627	17-7	1
2					SALARY=\$42,700						2
3	NOAH WOLFE							mngmnt fees	80,000	17-3	3
4											4
5	HELEN LACEK	MEMBER	ADMIN.	1.64	INNOVATIVE MGT			mngmnt fees	9,000	17-3	5
6					SALARY=\$121,169			SALARY	78,396	17-7	6
7	DONNA ATKIN	MEMBER	ADMIN.		see attached sch.			mngmnt fees	165,000	17-3	7
8	JOEL ATKIN	MEMBER	ADMIN	39.37	INNOVATIVE MGT			mngmnt fees	165,000	17-3	8
9					SALARY=\$33,400			SALARY	21,610	17-7	9
10					see attached sch.						10
11	JAY ORLINSKY	CFO	BANKING, A/R,		INNOVATIVE MGT			SALARY	66,252	17-7	11
12			A/P,ADMIN.		SALARY=\$102,400						12
13								TOTAL	\$ 612,885		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: 01/01/2006 Ending: 2/31/2006

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 INNOVATIVE HEALTHCARE
 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 SAL.-ELI ATKIN	PATIENT DAYS	146,261	4	\$ 42,700	\$ 42,700	94,630	\$ 27,627	1
2	17	OFFICER SAL.-JOEL ATKIN	PATIENT DAYS	146,261	4	33,400	33,400	94,630	21,610	2
3	17	ADMIN SAL.-ORLINSKY	PATIENT DAYS	146,261	4	102,400	102,400	94,630	66,252	3
4	17	ADMIN SAL.-LACEK	PATIENT DAYS	146,261	4	121,169	121,169	94,630	78,396	4
5	19	ACCOUNTING, DATA PROC.	PATIENT DAYS	146,261	4	9,728		94,630	6,294	5
6	21	OFFICE EXPENSE	PATIENT DAYS	146,261	4	24,670		94,630	15,961	6
7	21	CLERICAL SALARIES	PATIENT DAYS	146,261	4	184,460	184,460	94,630	119,345	7
8	27	PAY.TAXES & HEALTH INS	PATIENT DAYS	146,261	4	179,532		94,630	116,156	8
9	39	THERAPY SALARIES	DIRECT	1	1	21,065	21,065	1	21,065	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					\$ 719,124	\$ 505,194		\$ 472,706	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	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1							\$	\$			\$	1						
2												2						
3												3						
4												4						
5	B. LEHAMN	X		WORKING CAPITAL				250,000			0.0400	14,167	5					
Working Capital																		
6	IST BANK		X	WORKING CAPITAL	\$6,098.00	04/18/01			257,947		0.0700	23,822	6					
7	MB		X	WORKING CAPITAL	INT + \$25,000	08/11/08		300,000				5,949	7					
8	MB		X	WORKING CAPITAL	INT ONLY	01/07/05		1,759,613	2,000,000	REVOLV	prime +	168,700	8					
9	TOTAL Facility Related				\$6,098.00		\$	2,309,613	\$	2,257,947		\$	212,638	9				
B. Non-Facility Related*																		
10	IRS, IDR, ETC		X	LATE FEES									10					
11	BED TAX											16,646	11					
12													12					
13													13					
14	TOTAL Non-Facility Related						\$	0	\$	0		\$	16,646	14				
15	TOTALS (line 9+line14)						\$	2,309,613	\$	2,257,947		\$	229,284	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.)

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 2005 report.		\$	481,770	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	496,023	2
3. Under or (over) accrual (line 2 minus line 1).		\$	14,253	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	496,023	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	510,276	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	440,501	8
	2002	457,541	9
	2003	456,292	10
	2004	481,770	11
	2005	496,023	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2005	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

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 2005 TAX BILL.

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:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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.

2005 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 2005 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 2005.

(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>196,513.24</u>	\$ <u>196,513.24</u>
2. <u>09-11-306-006-0000</u>	<u>NURSING HOME</u>	\$ <u>196,429.90</u>	\$ <u>196,429.90</u>
3. <u>09-11-306-013-0000</u>	<u>NURSING HOME</u>	\$ <u>103,080.20</u>	\$ <u>103,080.20</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>496,023.34</u>	\$ <u>496,023.34</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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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: _____ 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).

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land. Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column for totals. Row 1: 1, 2, 3, \$, 1. Row 2: 2, 3, 4, \$, 2. Row 3: 3 TOTALS, 0, 3.

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

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		COMPRESSOR		2001	25,197	916	27.5	916		4,924	9
10		ELECTRICAL WIRING		2002	3,064	111	27.5	111		504	10
11		CLOSED CIRCUIT TV SYSTEM		2002	10,622	388	27.5	388		1,668	11
12		REPIPE LEAKING CONDENSOR		2002	2,994	107	27.5	107		580	12
13		SPRAY MISTER SYSTEM		2002	11,932	434	27.5	434		1,971	13
14		NEW GATE KEEPER		2002	3,710	135	27.5	135		613	14
15		CEILING TILE		2002	1,749	64	27.5	64		291	15
16		CARPETING		2002	21,788	1,757	5	4,358	2,601	19,611	16
17		PAINTING & WALLPAPER		2003	7,235	583	5	1,447	864	5,065	17
18		CAPETING		2003	17,812	1,436	5	3,562	2,126	12,467	18
19		WALL BASE & COVE		2003	936	76	5	187	111	655	19
20		HOUSE PUMP		2004	4,577	167	27.5	167		424	20
21		EXHAUST FOR SMOKING ROOM		2004	3,465	126	27.5	126		320	21
22		WET CHEMICAL FIRE SYSTEM		2004	3,200	116	27.5	116		295	22
23		AIR CONDITIONING COMPRESSORS		2004	21,500	782	27.5	782		1,988	23
24		STELL PEDESTRIAN DOOR		2005	1,965	71	27.5	71		110	24
25		A/C COMPRESSOR		2005	12,625	459	27.5	459		708	25
26		FOORING		2005	8,422	306	27.5	306		472	26
27		CONTROL PANEL FOR NURSE CALL SYSTEM		2005	2,213	81	27.5	81		124	27
28		CARPETING		2005	24,738	9,400	5	4,948	(4,452)	9,896	28
29		CARPETING		2006	872	174	5	174		174	29
30		COMPRESSORS		2006	20,844	411	27.5	411		411	30
31		ELECTRONIC DETECTOR EDGE FOR SERVICE ELEVATOR		2006	1,890	37	27.5	37		37	31
32		CHILLER		2006	11,822	233	27.5	233		233	32
33											33
34											34
35											35
36											36

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

See Page 12A, Line 70 for total

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

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	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70
			225,172	18,370	19,620	1,250	63,541	

**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	\$ 97,558	\$ 10,950	\$ 9,756	\$ (1,194)	10 YRS	\$ 39,025	71
72	Current Year Purchases	10,707	2,141	535	(1,606)	10 YRS	535	72
73	Fully Depreciated Assets				0			73
74					0			74
75	TOTALS	\$ 108,265	\$ 13,091	\$ 10,291	\$ (2,800)		\$ 39,560	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				\$	\$	\$	0		\$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 0	\$ 0	\$ 0	\$ 0		\$ 0	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)	\$ 333,437	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 31,461	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 29,911	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,550)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 103,101	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:	304	06/01/01	\$ 1,997,280			3
4	Additions						4
5							5
6							6
7	TOTAL	304		\$ 1,997,280			7

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

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

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ **84,971** 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	Patient Transportation	Ford E350 2003	\$ 575.00	\$ 7,244	17
18					18
19					19
20					20
21	TOTAL		\$ 575.00	\$ 7,244	21

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	/2007	\$ 2,002,448
13.	/2008	\$ 2,002,448
14.	/2009	\$ 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>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>		

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

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.)

	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	39-3	hrs	\$		\$ 3,630	\$		\$ 3,630	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			12,643			12,643	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 prescripts				144,920		144,920	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	I.V. Therapy	39-8				5,970			5,970	13
	Other (specify): Med. Supplies	39-8					20,128		20,128	
14	TOTAL			\$		\$ 22,243	\$ 165,048		\$ 187,291	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 **HAMPTON PLAZA NURSING & REHAB CENTER**

0045450

Report Period Beginning: **01/01/2006**

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2006**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 343,401	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,202,026		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	354,799		6
7	Other Prepaid Expenses	5,000		7
8	Accounts Receivable (owners or related parties)	917,854		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,823,080	\$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	151,791		15
16	Equipment, at Historical Cost	181,646		16
17	Accumulated Depreciation (book methods)	(170,125)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	35,556		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(35,556)		20
21	Restricted Funds			21
22	Other Long-Term Assets (spec comp. software)	11,170		22
23	Other(specify): <u>synd.fee/section 754</u>	224,953		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 399,435	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,222,515	\$ 0	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,533,818	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,934		28
29	Short-Term Notes Payable	2,257,947		29
30	Accrued Salaries Payable	272,826		30
31	Accrued Taxes Payable (excluding real estate taxes)	81,356		31
32	Accrued Real Estate Taxes(Sch.IX-B)	496,023		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,655,904	\$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 0	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,655,904	\$ 0	46
47	TOTAL EQUITY(page 18, line 24)	\$ (433,389)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,222,515	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,777,711	1
2	Restatements (describe):		2
3	POST CLOSING ADJ	(2,225,744)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (448,033)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	14,644	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)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 14,644	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (433,389)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number HAMPTON PLAZA NURSING & REHAB CENTI # 0045450Report Period Beginning: 01/01/2006Ending: 12/31/2006**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	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 13,661,617	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,661,617	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 0	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)	\$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	10	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 0	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,661,627	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,291,635	31
32	Health Care	5,532,335	32
33	General Administration	2,603,257	33
	B. Capital Expense		
34	Ownership	2,866,025	34
	C. Ancillary Expense		
35	Special Cost Centers	187,291	35
36	Provider Participation Fee	166,440	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,646,983	40
41	Income before Income Taxes (line 30 minus line 40)**	14,644	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 14,644	43

* 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.

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

0045450

Report Period Beginning: **01/01/2006**

Ending:

12/31/2006

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
2	Assistant Director of Nursing	1,476	1,856	56,829	30.62
3	Registered Nurses	55,805	64,326	1,833,715	28.51
4	Licensed Practical Nurses	16,321	18,357	461,855	25.16
5	CNAs & Orderlies	142,151	153,041	1,864,537	12.18
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides	18,029	19,013	490,819	25.81
9	Activity Director	1,976	2,070	36,897	17.82
10	Activity Assistants	18,637	20,311	211,806	10.43
11	Social Service Workers	8,695	9,197	120,093	13.06
12	Dietician				12
13	Food Service Supervisor	2,689	3,093	45,547	14.73
14	Head Cook	3,758	4,166	54,816	13.16
15	Cook Helpers/Assistants	42,645	46,540	468,819	10.07
16	Dishwashers				16
17	Maintenance Workers	9,478	9,856	148,926	15.11
18	Housekeepers	38,079	41,675	387,610	9.30
19	Laundry	8,491	9,489	102,752	10.83
20	Administrator	1,985	2,166	64,010	29.55
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	4,030	4,277	60,088	14.05
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	2,894	3,118	43,724	14.02
32	Other Health Care(specify)				32
33	Other(specify) <u>See Schedule</u>	15,174	16,222	276,097	17.02
34	TOTAL (lines 1 - 33)	392,313	428,773	\$ 6,728,940 *	\$ 15.69

* 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 43,000	9-3	36
37	Medical Records Consultant	0	10-3	37
38	Nurse Consultant	0	10-3	38
39	Pharmacist Consultant	Monthly Fee 2,948	10-3	39
40	Physical Therapy Consultant	0	10a-3	40
41	Occupational Therapy Consultant	0	10a-3	41
42	Respiratory Therapy Consultant	Monthly Fee 15,640	10a-3	42
43	Speech Therapy Consultant	0	10a-3	43
44	Activity Consultant	0	11-3	44
45	Social Service Consultant	0	12-3	45
46	Other(specify) <u>Psycho-Social</u>	Monthly Fee 300	10-3	46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 61,888		49

C. CONTRACT NURSES

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

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								
					FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1	PAINT/DECORATING	2002	\$ 4,000	3 YRS	\$ 1,333	\$ 1,333	\$ 667	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
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11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 4,000		\$ 1,333	\$ 1,333	\$ 667	\$	\$	\$	\$	\$	\$

Facility Name & ID Number HAMPTON PLAZA NURSING & REHAB CENTER# 0045450Report Period Beginning: 01/01/2006Ending: 12/31/2006**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 ASSOC. OF HEALTHCARE \$15760
- (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. \$ 36,135 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
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