

Facility Name & ID Number PLAZA TERRACE

0040386 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	48	Skilled (SNF)	48	17,520	1
2		Skilled Pediatric (SNF/PED)			2
3	44	Intermediate (ICF)	44	16,060	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	92	TOTALS	92	33,580	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	2,266	107	1,969	4,342	8
9	SNF/PED					9
10	ICF	20,390	963	1,994	23,347	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,656	1,070	3,963	27,689	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.46%

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 04/01/1993

J. Was the facility purchased or leased after January 1, 1978?
YES Date 04/01/1993 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 48 and days of care provided 1,969

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number **PLAZA TERRACE** # **0040386** 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	169,501	13,886	119	183,506		183,506	0	183,506		1
2	Food Purchase		151,742		151,742	(9,308)	142,434	(1,540)	140,894		2
3	Housekeeping	136,323	8,893	0	145,216		145,216	0	145,216		3
4	Laundry	0	7,455	0	7,455	0	7,455	0	7,455		4
5	Heat and Other Utilities			66,834	66,834		66,834	0	66,834		5
6	Maintenance	64,904	32,799	12,278	109,981		109,981	0	109,981		6
7	Other (specify):*			12,544	12,544		12,544	0	12,544		7
8	TOTAL General Services	370,728	214,775	91,775	677,278	(9,308)	667,970	(1,540)	666,430		8
	B. Health Care and Programs										
9	Medical Director	0		0	0		0	0	0		9
10	Nursing and Medical Records	985,370	126,084	7,128	1,118,582		1,118,582	0	1,118,582		10
10a	Therapy	15,034	1,219	0	16,253		16,253	0	16,253		10a
11	Activities	81,140	5,916	0	87,056		87,056	0	87,056		11
12	Social Services	0		0	0		0	0	0		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			245	245		245	0	245		14
15	Other (specify):*				0		0	0	0		15
16	TOTAL Health Care and Programs	1,081,544	133,219	7,373	1,222,136	0	1,222,136	0	1,222,136		16
	C. General Administration										
17	Administrative	73,380		277,000	350,380		350,380	56,732	407,112		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			42,635	42,635		42,635	(3,610)	39,025		19
20	Dues, Fees, Subscriptions & Promotions			28,039	28,039		28,039	(17,049)	10,990		20
21	Clerical & General Office Expenses	107,585	16,612	232,480	356,677		356,677	(174,329)	182,348		21
22	Employee Benefits & Payroll Taxes			277,813	277,813	9,308	287,121	0	287,121		22
23	Inservice Training & Education			0	0		0	0	0		23
24	Travel and Seminar			16,103	16,103		16,103	(2,065)	14,038		24
25	Other Admin. Staff Transportation			16,020	16,020		16,020	(9,443)	6,577		25
26	Insurance-Prop.Liab.Malpractice			79,602	79,602		79,602	0	79,602		26
27	Other (specify):*			30,000	30,000		30,000	3,988	33,988		27
28	TOTAL General Administration	180,965	16,612	999,692	1,197,269	9,308	1,206,577	(145,776)	1,060,801		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,633,237	364,606	1,098,840	3,096,683	0	3,096,683	(147,316)	2,949,367		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	119
		0
		119
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	30,237
	ELECTRICITY	25,950
	WATER	10,647
	CABLE TV - LOBBY	0
		0
		66,834
6	MAINTENANCE	
	GROUNDS MAINTENANCE	0
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	4,066
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	2,413
	FIRE SERVICE	5,799
		0
		0
		0
		0
		12,278
7	OTHER	
	SCAVENGER	12,544
	SECURITY SERVICE	0
		0
		0
		12,544
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	0
		0

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	4,661
	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	2,354
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	113
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		7,128
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	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
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	245
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	277,000
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	10,064
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	32,571
		0
		42,635
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	4,063
	EMPLOYEE WANT ADS XIX F	0
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	8,124
	LICENSES & PERMITS XIX F	1,742
	PUBLIC RELATIONS-PATIENT RELATED XIX F	12,986
	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	1,124
	PATIENT BACKGROUND CHECKS XIX F	0
		28,039
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	63,877
	EQUIPMENT REPAIR & MAINTENANCE	714
	OUTSIDE CLERICAL SERVICES	150,000
	PENALTIES / OVERDRAFT CHARGES VI 18	43
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	17,846
	MESSENGER SERVICE	0
		0
		232,480

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	124,711
	UNEMPLOYMENT COMPENSATION XIX D	50,814
	WORKERS COMPENSATION INSURANC XIX D	39,805
	HOSPITALIZATION INSURANCE XIX D	47,565
	EMPLOYEE BENEFITS - OTHER XIX D	0
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	14,918
	CHICAGO HEAD TAX XIX D	0
		0
		277,813
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	16,103
	TRAVEL XIX G	0
		16,103
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	16,020
		16,020
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	79,602
		79,602
27	OTHER	
	BAD DEBTS VI 24	30,000
		30,000

GRAND TOTAL COLUMN 3 OTHER

1,098,840

PLAZA TERRACE
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2006

TOTAL FOOD PURCHASE	151,742	PATIENT MEALS	83067
LESS SALES TAX	(1,540)	ADD EMPLOYEE MEALS	5475
	-----		-----
NET FOOD	150,202	TOTAL MEALS/YEAR	88542
TOTAL PATIENT CENSUS	27,689	NET FOOD	150202
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	88542

TOTAL PATIENT MEALS	83067	COST PER MEAL	1.7
		TIME EMPLOYEE MEALS	5475
ADD # EMPLOYEE MEALS/DAY	15		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	9308
	-----		=====
TOTAL EMPLOYEE MEALS	5475		

Facility Name & ID Number

PLAZA TERRACE

#0040386

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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			46,006	46,006		46,006	23,693	69,699			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			33,736	33,736		33,736	452,393	486,129			32
33	Real Estate Taxes			91,018	91,018		91,018	0	91,018			33
34	Rent-Facility & Grounds			508,500	508,500		508,500	(508,500)	0			34
35	Rent-Equipment & Vehicles			13,448	13,448		13,448	0	13,448			35
36	Other (specify):* amort software			1,241	1,241		1,241	0	1,241			36
37	TOTAL Ownership			693,949	693,949	0	693,949	(32,414)	661,535			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		69,136	238,918	308,054		308,054	30,140	338,194			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			49,841	49,841		49,841	0	49,841			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	69,136	288,759	357,895	0	357,895	30,140	388,035			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,633,237	433,742	2,081,548	4,148,527	0	4,148,527	(149,590)	3,998,937			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	(14,489)	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	(1,540)	2		13
14	Non-Care Related Interest	(6,601)	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	(43)	21		18
19	Entertainment	0	20		19
20	Contributions	0	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(5,452)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(30,000)	27		24
25	Fund Raising, Advertising and Promotional	(17,049)	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	(75,385)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (150,559)		\$ 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)	969		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 969		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (149,590)		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

PLAZA TERRACE

ID# 0040386

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 CHARGES	(63,877)	21	2
3	OUT OF STATE EDUCATION	(1,014)	24	3
4	SEMINAR ON MARKETING	(1,051)	24	4
5	NON ALLOWABLE TRAVEL	(9,443)	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	(75,385)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PLAZA TERRACE# 0040386 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	(1,540)	0	0	0	0	0	0	0	0	0	0	(1,540)	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	(1,540)	0	0	0	0	0	0	0	0	0	0	(1,540)	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	56,732	0	0	0	0	0	0	0	0	0	56,732	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,452)	1,842	0	0	0	0	0	0	0	0	0	(3,610)	19
20	Fees, Subscriptions & Promotions	(17,049)	0	0	0	0	0	0	0	0	0	0	(17,049)	20
21	Clerical & General Office Expenses	(63,920)	(110,409)	0	0	0	0	0	0	0	0	0	(174,329)	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	(2,065)	0	0	0	0	0	0	0	0	0	0	(2,065)	24
25	Other Admin. Staff Transportation	(9,443)	0	0	0	0	0	0	0	0	0	0	(9,443)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(30,000)	33,988	0	0	0	0	0	0	0	0	0	3,988	27
28	TOTAL General Administration	(127,929)	(17,847)	0	(145,776)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(129,469)	(17,847)	0	(147,316)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PLAZA TERRACE# 0040386

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	(14,489)	0	38,182	0	0	0	0	0	0	0	0	23,693	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,601)	0	458,994	0	0	0	0	0	0	0	0	452,393	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(508,500)	0	0	0	0	0	0	0	0	(508,500)	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	(21,090)	0	(11,324)	0	(32,414)	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	30,140	0	0	0	0	0	0	0	0	0	30,140	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	30,140	0	0	0	0	0	0	0	0	0	30,140	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(150,559)	12,293	(11,324)	0	(149,590)	45							

Facility Name & ID Number

PLAZA TERRACE

0040386

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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
DONNA ATKIN	30	SEE ATTACHED SCHEDULE		INNOVATIVE	NILES	MANAGEMENT
JOEL ATKIN	70			HEALTHCARE		

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	\$ 150,000	INNOVATIVE HEALTHCARE		\$	\$ (150,000)	1
2	V	39 THERAPY COSTS	178,227				(178,227)	2
3	V	17 OFFICER SAL.-ELI ATKIN				8,084	8,084	3
4	V	17 OFFICER SAL.-JOEL ATKIN				6,323	6,323	4
5	V	17 ADMIN SAL.-ORLINSKY				19,386	19,386	5
6	V	17 ADMIN SAL.-LACEK				22,939	22,939	6
7	V	19 ACCOUNTING, DATA PROC.				1,842	1,842	7
8	V	21 OFFICE EXPENSE				4,670	4,670	8
9	V	21 CLERICAL SALARIES				34,921	34,921	9
10	V	27 PAY.TAXES & HEALTH INS				33,988	33,988	10
11	V	39 THERAPY SALARIES				208,367	208,367	11
12	V							12
13	V							13
14	Total		\$ 328,227			\$ 340,520	\$ * 12,293	14

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

VII. RELATED PARTIES (continued)

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

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

1	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)
15	V	34 RENT	\$ 508,500	3249 W 147TH STREET LTD. PARTNERSHIP		\$	(508,500)
16	V	30 DEPRECIATION - BUILDING				38,182	38,182
17	V	32 INTEREST - MORTGAGE				458,994	458,994
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 508,500			\$ 497,176	\$ * (11,324)

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

Facility Name & ID Number

PLAZA TERRACE

#

0040386

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	DONNA ATKIN		ADMIN	30.00	SEE ATTACHED			mngmnt fees	\$ 137,000	17-3	1
2											2
3	ELISHA ATKIN		ADMIN., BANK, PURCHASING		innovative mngmt salary \$42,700			SALARY	8,084	17-7	3
4											4
5	HELEN LACEK		ADMIN		innovative mngmt salary \$121,169			SALARY	22,939	17-7	5
6								mngmnt fees	8,000	17-3	6
7											7
8	JOEL ATKIN		ADMIN	70.00	innovative mngmt salary \$33,400			SALARY	6,323	17-7	8
9								mngmnt fees	132,000	17-3	9
10					see attached sched						10
11	JAY ORLINSKY	CFO	BANKING, A/R, A.P, ADMIN		innovative mngmt salary \$102,400			SALARY	19,386	17-7	11
12											12
13								TOTAL	\$ 333,732		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 **PLAZA TERRACE**

0040386 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

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

Name of Related Organization INNOVATIVE HEALTHCARE
 Street Address 9777 N GREENWOOD
 City / State / Zip Code NILES
 Phone Number (847)470-0000
 Fax Number (847)470-0061

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	OFFICER SAL.-ELI ATKIN	PATIENT DAYS	146,261	4	\$ 42,700	\$ 27,689	\$ 8,084	1
2	17	OFFICER SAL.-JOEL ATKIN	PATIENT DAYS	146,261	4	33,400	27,689	6,323	2
3	17	ADMIN SAL.-ORLINSKY	PATIENT DAYS	146,261	4	102,400	27,689	19,386	3
4	17	ADMIN SAL.-LACEK	PATIENT DAYS	146,261	4	121,169	27,689	22,939	4
5	19	ACCOUNTING, DATA PROC.	PATIENT DAYS	146,261	4	9,728	27,689	1,842	5
6	21	OFFICE EXPENSE	PATIENT DAYS	146,261	4	24,670	27,689	4,670	6
7	21	CLERICAL SALARIES	PATIENT DAYS	146,261	4	184,460	27,689	34,921	7
8	27	PAY.TAXES & HEALTH INS	PATIENT DAYS	146,261	4	179,532	27,689	33,988	8
9	39	THERAPY SALARIES	DIRECT	1	1	208,367	200,526	1	208,367
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					\$ 906,426	\$ 684,655	\$ 340,520	25

Facility Name & ID Number **PLAZA TERRACE**

0040386 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

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

Name of Related Organization 3249 W 147TH STREET
 Street Address 9777 N GREENWOOD
 City / State / Zip Code NILES, IL
 Phone Number (847)470-0000
 Fax Number (847)470-0061

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION-BUILDING	DIRECT	1	1	\$ 38,182	1	\$ 38,182	1
2	32	INTEREST-MORTGAGE	DIRECT	1	1	458,994	1	458,994	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 497,176		\$ 497,176	25

Facility Name & ID Number **PLAZA TERRACE**

0040386

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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.		\$	58,112	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.)		\$	74,565	2
3. Under or (over) accrual (line 2 minus line 1).		\$	16,453	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	74,565	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.		\$	91,018	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	109,176	8
	2002	53,783	9
	2003	55,460	10
	2004	58,112	11
	2005	74,565	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 PLAZA TERRACE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0040386

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>28-11-408-003-0000</u>	<u>NURSING HOME</u>	\$ <u>71,131.71</u>	\$ <u>71,131.71</u>
2. <u>28-11-408-004-0000</u>	<u>NURSING HOME</u>	\$ <u>541.87</u>	\$ <u>541.87</u>
3. <u>28-11-408-050-0000</u>	<u>NURSING HOME</u>	\$ <u>2,891.57</u>	\$ <u>2,891.57</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>74,565.15</u>	\$ <u>74,565.15</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.

Facility Name & ID Number PLAZA TERRACE

0040386

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,780 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 1

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.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>FACILITY</u>		<u>1993</u>	<u>\$ 159,918</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 159,918	3

Facility Name & ID Number PLAZA TERRACE

0040386

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	92		1993		\$ 1,050,000	\$ 38,182	27.5	\$ 38,182	\$	\$ 521,441	4
5	6										5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS		1993		5,150	163	31.5	164	1	2,245	9
10	VARIOUS		1993		5,006	128	39	128		1,726	10
11	AIR CONDITIONER		1994		19,602	503	39	503		6,308	11
12	ALARM		1994		9,612	246	39	246		3,127	12
13	WALLPAPER		1994		12,345	317	39	317		3,840	13
14	SPRINKLER		1993		3,530		39	91	91	1,092	14
15	IMPROVEMENTS - P.A. AUDIT		1993		13,002		39	333	333	3,996	15
16	CEILING - P.A. AUDIT		1993		13,500		39	346	346	4,152	16
17	NURSES STATION - P.A. AUDIT		1993		1,500		39	38	38	456	17
18	ASBESTOS CONTROL - P.A. AUDIT		1993		1,800		39	46	46	552	18
19	NEW ROOF		1996		26,844	688	39	688		7,253	19
20	NEW WINDOWS		1996		64,075	1,643	39	1,643		17,320	20
21	GENERATOR		1998		57,400	1,472	39	1,472		13,186	21
22	NEW PARKING LOT		1998		37,750	968	39	968		8,026	22
23	NEW GENERATOR		1998		50,100	1,285	39	1,285		9,691	23
24	KITCHEN ADDITION		1999		175,000	4,487	39	4,487		33,840	24
25	FRONT OFFICE REMODELING		1999		17,000	436	39	436		3,288	25
26	CONVERSION OF LAUNDRY TO BATHROOM		1999		12,000	308	39	308		2,323	26
27	HANDRAILS		1999		12,216	313	39	313		2,361	27
28	KITCHEN IMPROVEMENT		1999		39,948	1,024	39	1,024		7,723	28
29	TRANSFORMER		2001		12,100	310	39	310		1,615	29
30	DOOR		2003		5,241	191	27.5	191		676	30
31	HEATING UNIT		2003		10,000	364	27.5	364		1,289	31
32	ELECTRICAL WORK		2003		3,150	114	27.5	114		404	32
33	DOORS		2004		21,594	785	27.5	785		1,799	33
34	CARPETING		2004		13,324	1,279	5	1,332	53	3,996	34
35	DOORS		2006		11,734	232	27.5	232		232	35
36	HEATING UNITS		2006		2,804	55	27.5	55		55	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	CARPETING	2006	\$ 4,711	\$ 942	5	\$ 942	\$	\$ 942	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)		\$ 1,712,038	\$ 56,435		\$ 57,343	\$ 908	\$ 664,954	70

**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	\$ 118,107	\$ 24,490	\$ 11,540	\$ (12,950)		\$ 33,930	71
72	Current Year Purchases	16,317	3,263	816	(2,447)		816	72
73	Fully Depreciated Assets	44,722			0		44,722	73
74					0			74
75	TOTALS	\$ 179,146	\$ 27,753	\$ 12,356	\$ (15,397)		\$ 79,468	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)	\$ 2,051,102	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 84,188	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 69,699	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (14,489)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 744,422	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: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		<u>92</u>		\$ <u>508,500</u>			3
4	Additions							4
5								5
6								6
7	TOTAL		92		\$ 508,500			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: \$ 4,613 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>ADMINISTRATOR</u>	<u>05 GMC 3500 VAN</u>	\$ <u>735.40</u>	\$ <u>8,835</u>	17
18					18
19					19
20					20
21	TOTAL		\$ 735.40	\$ 8,835	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 \$ _____

13. _____ /2008 \$ _____

14. _____ /2009 \$ _____

* 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	\$		\$ 84,515	\$		\$ 84,515	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			10,350			10,350	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			112,509			112,509	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				65,623		65,623	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 Other (specify): med. Supply, radiology	39-8				31,272 272	3,513		31,272 3,785	13
14	TOTAL			\$		\$ 238,918	\$ 69,136		\$ 308,054	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 PLAZA TERRACE

0040386

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	\$ 4,943	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 30,000)	1,140,104		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	112,464		6
7	Other Prepaid Expenses	829		7
8	Accounts Receivable (owners or related parties)	34,446		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,292,786	\$ 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	610,671		15
16	Equipment, at Historical Cost	197,181		16
17	Accumulated Depreciation (book methods)	(300,455)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>COMPUTER SOFTWARE</u>	30,375		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 537,772	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,830,558	\$ 0	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 733,635	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,388		28
29	Short-Term Notes Payable	188,500		29
30	Accrued Salaries Payable	34,731		30
31	Accrued Taxes Payable (excluding real estate taxes)	26,640		31
32	Accrued Real Estate Taxes(Sch.IX-B)	74,565		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>DUE TO AFFILIATES</u>	40,645		36
37	<u>DUE TO INOVATIVE HEALTHCARE</u>	514,665		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,619,769	\$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	631,112		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)	\$ 631,112	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,250,881	\$ 0	46
47	TOTAL EQUITY (page 18, line 24)	\$ (420,323)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,830,558	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 292,076	1
2	Restatements (describe):		2
3	POST CLOSING ADJ	33,224	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 325,300	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(745,623)	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)	\$ (745,623)	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)	\$ (420,323)	24 *

* 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	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,246,034	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,246,034	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	153,120	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 153,120	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***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 0	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	ADJ OF PRIOR YEAR EXPENSE	3,750	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,750	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,402,904	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	677,278	31
32	Health Care	1,222,136	32
33	General Administration	1,197,269	33
	B. Capital Expense		
34	Ownership	693,949	34
	C. Ancillary Expense		
35	Special Cost Centers	308,054	35
36	Provider Participation Fee	49,841	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,148,527	40
41	Income before Income Taxes (line 30 minus line 40)**	(745,623)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (745,623)	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 AT COST REPORT FILING

*** 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 PLAZA TERRACE

0040386

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	1,432	1,564	\$ 42,178	\$ 26.97	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,833	2,912	70,059	24.06	3
4	Licensed Practical Nurses	15,609	16,636	374,691	22.52	4
5	CNAs & Orderlies	52,134	55,039	494,423	8.98	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	792	808	15,034	18.61	8
9	Activity Director	2,046	2,086	39,516	18.94	9
10	Activity Assistants	3,372	3,462	41,624	12.02	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	417	476	9,840	20.67	13
14	Head Cook	8,966	9,896	109,896	11.11	14
15	Cook Helpers/Assistants	6,220	6,565	49,765	7.58	15
16	Dishwashers					16
17	Maintenance Workers	4,022	4,171	64,904	15.56	17
18	Housekeepers	14,982	15,647	136,323	8.71	18
19	Laundry					19
20	Administrator	2,274	2,442	73,380	30.05	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,030	7,399	107,585	14.54	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	166	166	4,019	24.21	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	122,295	129,269	\$ 1,633,237 *	\$ 12.63	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	M	\$ 0	1-3	35
36	Medical Director	O	0	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	2,354	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify) <u>Physicians</u>	S	113	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 2,467		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. 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	
LATONYA DAVIS	ADMINISTRATOR		\$ 73,380	Workers' Compensation Insurance	\$ 39,805	IDPH License Fee	\$	
			0	Unemployment Compensation Insurance	50,814	Advertising: Employee Recruitment	0	
				FICA Taxes	124,711	Health Care Worker Background Check	1,124	
				Employee Health Insurance	47,565	(Indicate # of checks performed)		
				Employee Meals	9,308	Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	0	
				EMPLOYEE BENEFITS - OTHER	0	MARKETING/ADV/PROMO	17,049	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	9,866	
				PENSION/PROFIT SHARING PLANS	14,918	MGMT CO ALLOC		
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	0	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(12,986)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(4,063)	
						Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 73,380	TOTAL (agree to Schedule V, line 22, col.8)	\$ 287,121	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 10,990	
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
HELEN LACEK			\$ 8,000			\$	Out-of-State Travel	\$
DONNA ATKIN			137,000					
JOEL ATKIN			132,000				In-State Travel	0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 277,000				Seminar Expense	16,103
C. Professional Services							NON ALLOWABLE SEMINARS	
Vendor/Payee	Type		Amount				(2,065)	
HEALTH DATA SYSTEM	DATA PROCESSING		\$ 5,408					
HEALTH DATA SOLUTIONS	DATA PROCESSING		3,675				Entertainment Expense	()
MEDIFAX	DATA PROCESSING		232				(agree to Sch. V, line 24, col. 8)	
AMERICAN DATA	DATA PROCESSING		749				TOTAL	\$ 14,038
KRUPNICK BOKOR, KAGDA	ACCOUNTING		19,250					
SACHNOFF & WEAVER	LEGAL FEES		90					
ARONBERG GOLDGEHN DAVIS	LEGAL FEES		4,035					
LARRY Y. SCHWARTZ	LEGAL FEES		1,367					
MEYER MEGANCE	LEGAL FEES		150					
TOHTZ COMPUTER	COMPUTER CONSULTANT		7,679					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 42,635	TOTAL		\$		

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PLAZA TERRACE# 0040386Report 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 \$7589
- (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. \$ 933 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 _____ 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. \$ 49,841
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. \$ 9,308 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