

Facility Name & ID Number HAMPTON PLAZA NURSING & REHAB CENTER

0045450 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	15,404	1,056	7,053	23,513	8
9	SNF/PED					9
10	ICF	73,487	846	1,158	75,491	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	88,891	1,902	8,211	99,004	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.22%

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 7,053

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number **HAMPTON PLAZA NURSING & REHAB C** # **0045450** Report Period Beginning: **01/01/2007** Ending: **12/31/2007**

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	561,053	46,067		607,120		607,120		607,120		1
2	Food Purchase		521,258		521,258	(24,382)	496,876	(1,351)	495,525		2
3	Housekeeping	366,716	50,781		417,497		417,497		417,497		3
4	Laundry	102,216	43,740		145,956		145,956		145,956		4
5	Heat and Other Utilities			321,146	321,146		321,146		321,146		5
6	Maintenance	108,391	22,447	113,545	244,383		244,383		244,383		6
7	Other (specify):* Security	31,372		38,409	69,781		69,781		69,781		7
8	TOTAL General Services	1,169,748	684,293	473,100	2,327,141	(24,382)	2,302,759	(1,351)	2,301,408		8
	B. Health Care and Programs										
9	Medical Director			58,000	58,000		58,000		58,000		9
10	Nursing and Medical Records	4,689,655	142,518	16,696	4,848,869		4,848,869		4,848,869		10
10a	Therapy	500,462	1,319		501,781		501,781		501,781		10a
11	Activities	280,326	24,664		304,990		304,990		304,990		11
12	Social Services	100,043			100,043		100,043		100,043		12
13	CNA Training										13
14	Program Transportation			282	282		282		282		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	5,570,486	168,501	74,978	5,813,965		5,813,965		5,813,965		16
	C. General Administration										
17	Administrative	78,447		693,000	771,447		771,447	(301,734)	469,713		17
18	Directors Fees										18
19	Professional Services			171,390	171,390		171,390	(10,836)	160,554		19
20	Dues, Fees, Subscriptions & Promotions			119,608	119,608		119,608	(79,329)	40,279		20
21	Clerical & General Office Expenses	71,430	45,144	442,909	559,483		559,483	(261,723)	297,760		21
22	Employee Benefits & Payroll Taxes			971,367	971,367	24,382	995,749		995,749		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,084	2,084		2,084	(447)	1,637		24
25	Other Admin. Staff Transportation			10,938	10,938		10,938	(200)	10,738		25
26	Insurance-Prop.Liab.Malpractice			307,136	307,136		307,136		307,136		26
27	Other (specify):*			60,000	60,000		60,000	(21,930)	38,070		27
28	TOTAL General Administration	149,877	45,144	2,778,432	2,973,453	24,382	2,997,835	(676,199)	2,321,636		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,890,111	897,938	3,326,510	11,114,559		11,114,559	(677,550)	10,437,009		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	99,450
	ELECTRICITY	151,864
	WATER	68,154
	CABLE TV - LOBBY	1,678
		0
		321,146
6	MAINTENANCE	
	GROUNDS MAINTENANCE	7,892
	PAINTING & DECORATING	0
	BUILDING REPAIRS	8,234
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	52,254
	ELEVATOR MAINTENANCE & REPAIR	40,151
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	4,560
	FIRE SERVICE	454
		0
		0
		0
		0
		113,545
7	OTHER	
	SCAVENGER	38,409
	SECURITY SERVICE	0
		0
		0
		38,409
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	58,000
		58,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	10,289
	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	6,407
	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
		16,696
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN 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 CONSULTAN 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	282
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	693,000
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	19,131
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	152,259
		0
		171,390
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	76,479
	EMPLOYEE WANT ADS XIX F	5,749
	CONTRIBUTIONS VI 20 XIX F	2,400
	DUES & SUBSCRIPTIONS XIX F	19,785
	LICENSES & PERMITS XIX F	9,989
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	450
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	4,756
	PATIENT BACKGROUND CHECKS XIX F	0
		119,608
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	24,360
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	374,000
	PENALTIES / OVERDRAFT CHARGES VI 18	9,914
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	34,533
	MESSENGER SERVICE	102
		0
		442,909

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	518,089
	UNEMPLOYMENT COMPENSATION XIX D	72,678
	WORKERS COMPENSATION INSURANC XIX D	121,123
	HOSPITALIZATION INSURANCE XIX D	198,745
	EMPLOYEE BENEFITS - OTHER XIX D	2,344
	EMPLOYEE PHYSICAL EXAMS XIX D	136
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION / UNION XIX D	58,252
	CHICAGO HEAD TAX XIX D	0
		0
		971,367
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	2,084
	TRAVEL XIX G	0
		2,084
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	10,938
		10,938
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	307,136
		307,136
27	OTHER	
	BAD DEBTS VI 24	60,000
		60,000

GRAND TOTAL COLUMN 3 OTHER

3,326,510

**HAMPTON PLAZA NURSING & REHAB CENTER
SCHEDULES
12/31/2007**

**EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22**

TOTAL FOOD PURCHASE	521,258
LESS SALES TAX	<u>(1,351)</u>
NET FOOD	519,907

TOTAL PATIENT CENSUS	99,004
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	297,012

ADD # EMPLOYEE MEALS/DAY	40
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	14,600

PATIENT MEALS	297,012
ADD EMPLOYEE MEALS	<u>14,600</u>
TOTAL MEALS/YEAR	311,612

NET FOOD	519,907
DIVIDE TOTAL MEALS/YEAR	<u>311,612</u>

COST PER MEAL	1.67
TIME EMPLOYEE MEALS	<u>14,600</u>
EMPLOYEE MEAL RECLASSIFICATION	24,382

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			31,584	31,584		31,584	(220)	31,364		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			232,091	232,091		232,091	(16,825)	215,266		32
33	Real Estate Taxes			504,216	504,216		504,216		504,216		33
34	Rent-Facility & Grounds			1,997,280	1,997,280		1,997,280		1,997,280		34
35	Rent-Equipment & Vehicles			40,479	40,479		40,479		40,479		35
36	Other (specify):* SECTION 754			2,545	2,545		2,545		2,545		36
37	TOTAL Ownership			2,808,195	2,808,195		2,808,195	(17,045)	2,791,150		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		377,869	131,961	509,830		509,830	6,128	515,958		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			166,440	166,440		166,440		166,440		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		377,869	298,401	676,270		676,270	6,128	682,398		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,890,111	1,275,807	6,433,106	14,599,024		14,599,024	(688,467)	13,910,557		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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(220)	30		9
10	Interest and Other Investment Income	(179)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,351)	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		20		17
18	Fines and Penalties	(9,914)	21		18
19	Entertainment		20		19
20	Contributions	(2,400)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(60,000)	27		24
25	Fund Raising, Advertising and Promotional	(76,479)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(450)	20		28
29	Other-Attach Schedule	(38,057)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (205,696)		\$	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)	(482,771)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (482,771)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (688,467)		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: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$	6	1
2	BANK CHARGES	(24,360)	21	2
3	LEGAL INV. OUT OF PERIOD-SCHWARTZ	(120)	19	3
4	LEGAL INV. OUT OF PERIOD-MAINZER	(285)	19	4
5	LEGAL INV. OUT OF PERIOD-MAGENGE	(160)	19	5
6	EDUCATION - OUT OF STATE	(447)	24	6
7	TRANS STAFF- NOT ON SCHEDULE	(200)	25	7
8	LEGAL- AMERICAN EXPRESS	(11,143)	19	8
9	LEGAL-L SCHWARTZ	(1,342)	19	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	(38,057)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	(1,351)	0	0	0	0	0	0	0	0	0	0	(1,351)	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	(1,351)	0	0	0	0	0	0	0	0	0	0	(1,351)	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	124,641	(426,375)	0	0	0	0	0	0	0	0	(301,734)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(13,050)	2,214	0	0	0	0	0	0	0	0	0	(10,836)	19
20	Fees, Subscriptions & Promotions	(79,329)	0	0	0	0	0	0	0	0	0	0	(79,329)	20
21	Clerical & General Office Expenses	(34,274)	(231,627)	4,178	0	0	0	0	0	0	0	0	(261,723)	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	(447)	0	0	0	0	0	0	0	0	0	0	(447)	24
25	Other Admin. Staff Transportation	(200)	0	0	0	0	0	0	0	0	0	0	(200)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(60,000)	30,902	7,168	0	0	0	0	0	0	0	0	(21,930)	27
28	TOTAL General Administration	(187,300)	(73,870)	(415,029)	0	(676,199)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(188,651)	(73,870)	(415,029)	0	(677,550)	29							

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	(220)	0	0	0	0	0	0	0	0	0	0	(220)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(16,825)	0	0	0	0	0	0	0	0	0	0	(16,825)	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	(17,045)	0	0	0	0	0	0	0	0	0	0	(17,045)	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	6,128	0	0	0	0	0	0	0	0	0	6,128	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	6,128	0	0	0	0	0	0	0	0	0	6,128	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(205,696)	(67,742)	(415,029)	0	(688,467)	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	BOOKKEEPING
				HEALTHCARE		
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		I H		
				MANAGEMENT	NILES	MANAGEMENT

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	\$ 374,000	INNOVATIVE HEALTHCARE		\$	\$ (374,000)	1
2	V	39 THERAPY COSTS	127,885				(127,885)	2
3	V	17 ADMIN SAL.-ORLINSKY				53,973	53,973	3
4	V	17 ADMIN SAL.-LACEK				70,668	70,668	4
5	V	19 ACCOUNTING, DATA PROC.				2,214	2,214	5
6	V	21 OFFICE EXPENSE				30,665	30,665	6
7	V	21 CLERICAL SALARIES				111,708	111,708	7
8	V	27 PAY.TAXES & HEALTH INS				18,727	18,727	8
9	V	27 PAY.TAXES & HEALTH INS				12,175	12,175	9
10	V	39 THERAPY SALARIES				134,013	134,013	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 501,885			\$ 434,143	\$ * (67,742)	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	17 MANAGEMENT FEES	\$ 567,000	I H MANAGEMENT		\$	(567,000)
16	V	17 SALARY- ELISHA ATKIN				53,973	53,973
17	V	17 SALARY- DONNA ATKIN				32,890	32,890
18	V	17 MANAGE. FEE- JOEL ATKIN				53,762	53,762
19	V	21 TELEPHONE				4,178	4,178
20	V	27 PAYROLL TAXES				7,168	7,168
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		\$ 567,000			\$ 151,971	\$ * (415,029)

* 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: 01/01/2007 Ending: 12/31/2007

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	ADMINISTRATIVE	ADMIN.,PURCH		I H MANAGEMEN	SEE	ATTACHED	SALARY	\$ 53,973	17-7	1
2					SALARY=\$102,400						2
3	NOAH WOLFE					SEE	ATTACHED	mngmnt fees	96,000	17-3	3
4											4
5	HELEN LACEK	MEMBER	ADMIN.	1.64	INNOVATIVE MGT	SEE	ATTACHED	mngmnt fees	12,000	17-3	5
6					SALARY=\$134,076			SALARY	70,668	17-7	6
7	DONNA ATKIN	MEMBER	ADMIN.		I h mnmnt	SEE	ATTACHED	SALARY	32,890	17-7	7
8					salary= \$62,400						8
9	JOEL ATKIN	MEMBER	ADMIN	40.03	I H MANAGEMEN	SEE	ATTACHED	mngmnt fees	53,762	17-7	9
10					mnmgt fee-\$102,000						10
11	JAY ORLINSKY	CFO	BANKING, A/R,		INNOVATIVE MGT			SALARY	53,973	17-7	11
12			A/P,ADMIN.		SALARY=\$102,400						12
13								TOTAL	\$ 373,266		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: 01/01/2007 Ending: 2/31/2007

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 W. GREENWOOD
 City / State / Zip Code NILES, IL 60714-1002
 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	ADMIN SAL.-ORLINSKY	PATIENT DAYS	187,836	5	\$ 102,400	\$ 99,004	\$ 53,973	1
2	17	ADMIN SAL.-LACEK	PATIENT DAYS	187,836	5	134,076	99,004	70,668	2
3	19	ACCOUNTING, DATA PROC.	PATIENT DAYS	187,836	5	4,200	99,004	2,214	3
4	21	OFFICE EXPENSE	PATIENT DAYS	187,836	5	58,180	99,004	30,665	4
5	21	CLERICAL SALARIES	PATIENT DAYS	187,836	5	211,938	99,004	111,708	5
6	27	PAY.TAXES & HEALTH INS	PATIENT DAYS	187,836	5	35,529	99,004	18,727	6
7	27	PAY.TAXES & HEALTH INS	DIRECT	1	1	12,175	1	12,175	7
8	39	THERAPY SALARIES	DIRECT	1	1	134,013	1	134,013	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					\$ 692,511	\$ 582,427	\$ 434,143	25

Facility Name & ID Number HAMPTON PLAZA NURSING & REHAB CENTER # 0045450 Report Period Beginning: 01/01/2007 Ending: 2/31/2007

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 IH MANAGEMENT
 Street Address 9777 N. GREENWOOD
 City / State / Zip Code NILES, IL 60626-1418
 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	SALARY- ELISHA ATKIN	PER RESIDENT DAY	187,836	5	\$ 102,400	\$ 99,004	\$ 53,973	1
2	17	SALARY- DONNA ATKIN	PER RESIDENT DAY	187,836	5	62,400	99,004	32,890	2
3	17	MANAGE. FEE- JOEL ATKIN	PER RESIDENT DAY	187,836	5	102,000	99,004	53,762	3
4	21	TELEPHONE	PER RESIDENT DAY	187,836	5	7,927	99,004	4,178	4
5	27	PAYROLL TAXES	PER RESIDENT DAY	187,836	5	13,600	99,004	7,168	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					\$ 288,327	\$ 164,800	\$ 151,971	25

Facility Name & ID Number

HAMPTON PLAZA NURSING & REHAB C

0045450

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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												5						
Working Capital																		
6	IST BANK		X	WORKING CAPITAL	\$6,098.00	04/18/01		189,577		0.0700	14,667	6						
7	MB		X	WORKING CAPITAL	INT ONLY	01/07/05	1,759,613				59,125	7						
8	BANK LEUMI		X	WORKING CAPITAL	INT ONLY	05/07/07	2,297,000	2,500,000	04/08/08	prime +	141,653	8						
9	TOTAL Facility Related				\$6,098.00		\$ 4,056,613	\$ 2,689,577			\$ 215,445	9						
B. Non-Facility Related*																		
10	BED TAX										16,646	10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ 16,646	14						
15	TOTALS (line 9+line14)						\$ 4,056,613	\$ 2,689,577			\$ 232,091	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 2006 report.		\$	496,023	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.)		\$	500,120	2
3. Under or (over) accrual (line 2 minus line 1).		\$	4,096	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	500,120	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.		\$	504,216	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	457,541	8
	2003	456,292	9
	2004	481,770	10
	2005	496,023	11
	2006	500,120	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2006	\$	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 2006 TAX BILL.

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 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 2006 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 2006.

(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>198,136.15</u>	\$ <u>198,136.15</u>
2. <u>09-11-306-006-0000</u>	<u>NURSING HOME</u>	\$ <u>198,052.12</u>	\$ <u>198,052.12</u>
3. <u>09-11-306-013-0000</u>	<u>NURSING HOME</u>	\$ <u>103,931.51</u>	\$ <u>103,931.51</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>500,119.78</u>	\$ <u>500,119.78</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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.

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

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

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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		5,840	9
10		ELECTRICAL WIRING		2002	3,064	111	27.5	111		615	10
11		CLOSED CIRCUIT TV SYSTEM		2002	10,622	388	27.5	388		2,056	11
12		REPIPE LEAKING CONDENSOR		2002	2,994	107	27.5	107		687	12
13		SPRAY MISTER SYSTEM		2002	11,932	434	27.5	434		2,405	13
14		NEW GATE KEEPER		2002	3,710	135	27.5	135		748	14
15		CEILING TILE		2002	1,749	64	27.5	64		355	15
16		CARPETING		2002	21,788	879	5	2,177	1,298	21,788	16
17		PAINTING & WALLPAPER		2003	7,235	583	5	1,447	864	6,512	17
18		CAPETING		2003	17,812	1,436	5	3,562	2,126	16,029	18
19		WALL BASE & COVE		2003	936	76	5	187	111	842	19
20		HOUSE PUMP		2004	4,577	167	27.5	167		591	20
21		EXHAUST FOR SMOKING ROOM		2004	3,465	126	27.5	126		446	21
22		WET CHEMICAL FIRE SYSTEM		2004	3,200	116	27.5	116		411	22
23		AIR CONDITIONING COMPRESSORS		2004	21,500	782	27.5	782		2,770	23
24		STELL PEDESTRIAN DOOR		2005	1,965	71	27.5	71		181	24
25		A/C COMPRESSOR		2005	12,625	459	27.5	459		1,167	25
26		FOORING		2005	8,422	306	27.5	306		778	26
27		CONTROL PANEL FOR NURSE CALL SYSTEM		2005	2,213	81	27.5	81		205	27
28		CARPETING		2005	24,738	5,640	5	4,948	(692)	14,844	28
29		CARPETING		2006	872	279	5	174	(105)	348	29
30		COMPRESSORS		2006	20,844	758	27.5	758		1,169	30
31		ELECTRONIC DETECTOR EDGE FOR SERVICE ELEVATOR		2006	1,890	69	27.5	69		106	31
32		CHILLER		2006	11,822	430	27.5	430		663	32
33		BOILER		2007	12,747	251	27.5	251		251	33
34		ELEVATOR REHAB		2007	16,450	325	27.5	325		325	34
35		FIRE ALARM TAMPER SWITCHES		2007	5,496	108	27.5	108		108	35
36		DOORS		2007	3,053	60	27.5	60		60	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)		\$ 262,918	\$ 15,157		\$ 18,759	\$ 3,602	\$ 82,300	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	\$ 108,265	\$ 9,314	\$ 10,827	\$ 1,513	10 YRS	\$ 50,387	71
72	Current Year Purchases	35,564	7,113	1,778	(5,335)	10 YRS	1,778	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 143,829	\$ 16,427	\$ 12,605	\$ (3,822)		\$ 52,165	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 406,747	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 31,584	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 31,364	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (220)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 134,465	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: \$ 37,561 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 TRANSPOR	FORD E350 2003	\$ 575.00	\$ 2,918	17
18					18
19					19
20					20
21	TOTAL		\$ 575.00	\$ 2,918	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. _____/2008 \$ 1,997,280

13. _____/2009 \$ 1,997,280

14. _____/2010 \$ 1,997,280

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	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	\$		\$			\$	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			127,885			127,885	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				353,130		353,130	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	IV THERAPY Other (specify): supplies	39-8 39-8				4,076	24,739		4,076 24,739	13
14	TOTAL			\$		\$ 131,961	\$ 377,869		\$ 509,830	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: **01/01/2007**

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2007**

(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	\$ 37,538	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>60,000</u>)	2,834,775		3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	404,151		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	932,097		8
9	Other(specify): <u>PATIENT PERSONAL ITEMS</u>	44,638		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,253,199	\$	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	189,537		15
16	Equipment, at Historical Cost	217,210		16
17	Accumulated Depreciation (book methods)	(190,539)		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>synd.fee/section 754</u>	222,408		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 438,616	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,691,815	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,293,789	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,044		28
29	Short-Term Notes Payable	2,699,174		29
30	Accrued Salaries Payable	295,080		30
31	Accrued Taxes Payable (excluding real estate taxes)	81,341		31
32	Accrued Real Estate Taxes(Sch.IX-B)	500,120		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)	\$ 4,877,548	\$	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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,877,548	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (185,733)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,691,815	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (433,389)	1
2	Restatements (describe):		2
3	POST CLOSING ADJ	5,003	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (428,386)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	242,653	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)	\$ 242,653	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (185,733)	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	\$ 14,690,704	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 14,690,704	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)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	179	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 179	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	ADJUSTMENT PRIOR YEARS EXP	150,794	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 150,794	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,841,677	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,327,141	31
32	Health Care	5,813,965	32
33	General Administration	2,973,453	33
	B. Capital Expense		
34	Ownership	2,808,195	34
	C. Ancillary Expense		
35	Special Cost Centers	509,830	35
36	Provider Participation Fee	166,440	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,599,024	40
41	Income before Income Taxes (line 30 minus line 40)**	242,653	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 242,653	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 TIME

*** 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: 01/01/2007

Ending: 12/31/2007

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	1,393	1,676	\$ 43,266	\$ 25.82	1
2	Assistant Director of Nursing					2
3	Registered Nurses	52,561	61,844	1,867,670	30.20	3
4	Licensed Practical Nurses	14,826	17,938	458,388	25.55	4
5	CNAs & Orderlies	153,200	166,706	2,077,898	12.46	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	15,129	15,200	500,462	32.93	8
9	Activity Director	1,961	2,030	36,334	17.90	9
10	Activity Assistants	22,057	23,706	243,992	10.29	10
11	Social Service Workers	5,896	8,402	100,043	11.91	11
12	Dietician					12
13	Food Service Supervisor	2,264	2,500	36,435	14.57	13
14	Head Cook	5,614	5,901	79,874	13.54	14
15	Cook Helpers/Assistants	33,785	36,850	444,744	12.07	15
16	Dishwashers					16
17	Maintenance Workers	6,480	7,109	108,391	15.25	17
18	Housekeepers	33,850	37,109	366,716	9.88	18
19	Laundry	8,425	9,537	102,216	10.72	19
20	Administrator	1,997	2,086	78,447	37.61	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	541	558	12,321	22.08	23
24	Clerical	3,981	4,479	59,109	13.20	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	1,060	1,200	14,822	12.35	31
32	Other Health Care(specify)	12,773	13,355	227,611	17.04	32
33	Other(specify) <u>Security</u>	1,828	2,005	31,372	15.65	33
34	TOTAL (lines 1 - 33)	379,621	420,191	\$ 6,890,111 *	\$ 16.40	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	58,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	6,407	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)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 64,407		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	
JAMIE DLATT	ADMINISTRATOR		\$ 78,447	Workers' Compensation Insurance	\$ 121,123	IDPH License Fee	\$	
			0	Unemployment Compensation Insurance	72,678	Advertising: Employee Recruitment	5,749	
			0	FICA Taxes	518,089	Health Care Worker Background Check	4,756	
				Employee Health Insurance	198,745	(Indicate # of checks performed)		
				Employee Meals	24,382	Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	2,400	
				EMPLOYEE BENEFITS - OTHER	2,344	MARKETING/ADV/PROMO	76,929	
				EMPLOYEE PHYSICAL EXAMS	136	LICENSES/DUES/SUBSCRIPTIONS	29,774	
				PENSION/PROFIT SHARING PLANS	58,252	MGMT CO ALLOC		
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(2,400)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense (0	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(76,479)	
						Yellow page advertising	(450)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 78,447	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
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
I H MANAGEMENT - MANAGEMENT FEES			\$ 567,000			\$	Out-of-State Travel	\$ (447)
MENACHEM SHABAT - MANAGEMENT FEES			18,000					
HELEN LACEK - MANAGEMENT FEES			12,000				In-State Travel	0
NOAH WOLFF - MANAGEMENT FEES			96,000					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 693,000				Seminar Expense	2,084
C. Professional Services								
Vendor/Payee	Type		Amount				Entertainment Expense (
			\$				(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 1,637
SEE SCHEDULE ATTACHED			171,390					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 171,390	TOTAL		\$		

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number HAMPTON PLAZA NURSING & REHAB CENTER# 0045450Report Period Beginning: 01/01/2007Ending: 12/31/2007**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 \$19280
- (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. \$ 24,382 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees