

Facility Name & ID Number PLAZA TERRACE

0040386 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	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	2,234	79	1,819	4,132	8
9	SNF/PED					9
10	ICF	20,107	709	1,794	22,610	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,341	788	3,613	26,742	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.64%

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 1,819

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 **PLAZA TERRACE** # **0040386** 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	172,570	10,631		183,201		183,201		183,201		1
2	Food Purchase		135,864		135,864	(8,074)	127,790	(1,113)	126,677		2
3	Housekeeping	139,763	12,829		152,592		152,592		152,592		3
4	Laundry		5,436		5,436		5,436		5,436		4
5	Heat and Other Utilities			63,562	63,562		63,562		63,562		5
6	Maintenance	66,980	28,232	16,902	112,114		112,114		112,114		6
7	Other (specify):*			17,934	17,934		17,934		17,934		7
8	TOTAL General Services	379,313	192,992	98,398	670,703	(8,074)	662,629	(1,113)	661,516		8
	B. Health Care and Programs										
9	Medical Director			16,000	16,000		16,000		16,000		9
10	Nursing and Medical Records	1,021,645	77,081	6,547	1,105,273		1,105,273		1,105,273		10
10a	Therapy		547		547		547		547		10a
11	Activities	90,559	7,303		97,862		97,862		97,862		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,112,204	84,931	22,547	1,219,682		1,219,682		1,219,682		16
	C. General Administration										
17	Administrative	80,069		188,000	268,069		268,069	(105,348)	162,721		17
18	Directors Fees										18
19	Professional Services			57,068	57,068		57,068	598	57,666		19
20	Dues, Fees, Subscriptions & Promotions			22,168	22,168		22,168	(6,584)	15,584		20
21	Clerical & General Office Expenses	114,354	12,449	225,544	352,347		352,347	(171,191)	181,156		21
22	Employee Benefits & Payroll Taxes			313,115	313,115	8,074	321,189		321,189		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,735	5,735		5,735		5,735		24
25	Other Admin. Staff Transportation			4,796	4,796		4,796		4,796		25
26	Insurance-Prop.Liab.Malpractice			104,445	104,445		104,445		104,445		26
27	Other (specify):*			30,000	30,000		30,000	(6,035)	23,965		27
28	TOTAL General Administration	194,423	12,449	950,871	1,157,743	8,074	1,165,817	(288,560)	877,257		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,685,940	290,372	1,071,816	3,048,128		3,048,128	(289,673)	2,758,455		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	19,948
	ELECTRICITY	31,066
	WATER	12,548
	CABLE TV - LOBBY	0
		0
		63,562
6	MAINTENANCE	
	GROUNDS MAINTENANCE	840
	PAINTING & DECORATING	0
	BUILDING REPAIRS	5,602
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	2,381
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,149
	FIRE SERVICE	6,930
		0
		0
		0
		0
		16,902
7	OTHER	
	SCAVENGER	17,934
	SECURITY SERVICE	0
		0
		0
		17,934
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	16,000
		16,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	4,134
	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	2,413
	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
		6,547
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	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	188,000
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	14,767
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	42,301
		0
		57,068
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	6,584
	EMPLOYEE WANT ADS XIX F	45
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	7,346
	LICENSES & PERMITS XIX F	4,765
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	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	3,350
	PATIENT BACKGROUND CHECKS XIX F	78
		22,168
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	60,776
	EQUIPMENT REPAIR & MAINTENANCE	625
	OUTSIDE CLERICAL SERVICES	150,000
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	14,143
	MESSENGER SERVICE	0
		0
		225,544

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	128,694
	UNEMPLOYMENT COMPENSATION XIX D	65,317
	WORKERS COMPENSATION INSURANC XIX D	51,884
	HOSPITALIZATION INSURANCE XIX D	51,481
	EMPLOYEE BENEFITS - OTHER XIX D	15,739
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		313,115
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	5,735
	TRAVEL XIX G	0
		5,735
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	4,796
		4,796
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	104,445
		104,445
27	OTHER	
	BAD DEBTS VI 24	30,000
		30,000

GRAND TOTAL COLUMN 3 OTHER

1,071,816

**PLAZA TERRACE
SCHEDULES
12/31/2007**

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

TOTAL FOOD PURCHASE	135,864
LESS SALES TAX	<u>(1,113)</u>
NET FOOD	134,751

TOTAL PATIENT CENSUS	26,742
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	80,226

ADD # EMPLOYEE MEALS/DAY	14
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	5,110

PATIENT MEALS	80,226
ADD EMPLOYEE MEALS	<u>5,110</u>
TOTAL MEALS/YEAR	85,336

NET FOOD	134,751
DIVIDE TOTAL MEALS/YEAR	<u>85,336</u>

COST PER MEAL	1.58
TIME EMPLOYEE MEALS	<u>5,110</u>
EMPLOYEE MEAL RECLASSIFICATION	8,074

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Facility Name & ID Number PLAZA TERRACE

#0040386

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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			41,427	41,427		41,427	67,390	108,817			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			27,784	27,784		27,784	385,368	413,152			32
33	Real Estate Taxes			85,013	85,013		85,013		85,013			33
34	Rent-Facility & Grounds			508,500	508,500		508,500	(508,500)				34
35	Rent-Equipment & Vehicles			3,618	3,618		3,618		3,618			35
36	Other (specify):*											36
37	TOTAL Ownership			666,342	666,342		666,342	(55,742)	610,600			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		82,504	160,386	242,890		242,890	68,946	311,836			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			50,376	50,376		50,376		50,376			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		82,504	210,762	293,266		293,266	68,946	362,212			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,685,940	372,876	1,948,920	4,007,736		4,007,736	(276,469)	3,731,267			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	29,208	30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,113)	2		13
14	Non-Care Related Interest	(9,164)	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		21		18
19	Entertainment		20		19
20	Contributions		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	(30,000)	27		24
25	Fund Raising, Advertising and Promotional	(6,584)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(60,776)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (78,429)		\$	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)	(198,040)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (198,040)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (276,469)		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: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 0	6	1
2	BANK CHARGES	(60,776)	21	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				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	(60,776)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PLAZA TERRACE# 0040386 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	(1,113)	0	0	0	0	0	0	0	0	0	0	(1,113)	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	(1,113)	0	0	0	0	0	0	0	0	0	0	(1,113)	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	33,667	(139,015)	0	0	0	0	0	0	0	0	(105,348)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	598	0	0	0	0	0	0	0	0	0	598	19
20	Fees, Subscriptions & Promotions	(6,584)	0	0	0	0	0	0	0	0	0	0	(6,584)	20
21	Clerical & General Office Expenses	(60,776)	(111,544)	1,129	0	0	0	0	0	0	0	0	(171,191)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(30,000)	22,029	1,936	0	0	0	0	0	0	0	0	(6,035)	27
28	TOTAL General Administration	(97,360)	(55,250)	(135,950)	0	(288,560)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(98,473)	(55,250)	(135,950)	0	(289,673)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PLAZA TERRACE# 0040386

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	29,208	0	0	38,182	0	0	0	0	0	0	0	67,390	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,164)	0	0	394,532	0	0	0	0	0	0	0	385,368	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	(508,500)	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	20,044	0	0	(75,786)	0	(55,742)	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	68,946	0	0	0	0	0	0	0	0	0	68,946	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	68,946	0	0	0	0	0	0	0	0	0	68,946	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(78,429)	13,696	(135,950)	(75,786)	0	(276,469)	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				
				3249 W 147TH STREET		
				LTD PARTNERSHIP	NILES	REAL ESTATE
				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	\$ 150,000	INNOVATIVE HEALTHCARE		\$	\$ (150,000)	1
2	V	39 THERAPY COSTS	99,946				(99,946)	2
3	V	17 ADMIN SAL.-ORLINSKY				14,579	14,579	3
4	V	17 ADMIN SAL.-LACEK				19,088	19,088	4
5	V	19 ACCOUNTING, DATA PROC.				598	598	5
6	V	21 OFFICE EXPENSE				8,283	8,283	6
7	V	21 CLERICAL SALARIES				30,173	30,173	7
8	V	27 PAY.TAXES & HEALTH INS				5,058	5,058	8
9	V	27 PAY.TAXES & HEALTH INS				16,971	16,971	9
10	V	39 THERAPY SALARIES				168,892	168,892	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 249,946			\$ 263,642	\$ * 13,696	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	\$ 177,000	I H MANAGEMENT		\$	(177,000)
16	V	17 SALARY-ELI ATKIN				14,579	14,579
17	V	17 SALARY-DONNA ATKIN				8,884	8,884
18	V	17 MANAGE. FEE- JOEL ATKIN				14,522	14,522
19	V	21 TELEPHONE				1,129	1,129
20	V	27 PAYROLL TAXES				1,936	1,936
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		\$ 177,000			\$ 41,050	\$ * (135,950)

* 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				394,532	394,532
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			\$ 432,714	\$ * (75,786)

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

Facility Name & ID Number

PLAZA TERRACE

#

0040386

Report Period Beginning:

01/01/2007

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		ADMIN.,PURCH		I H MANAGEMEN	see	attached	SALARY	\$ 14,579	17-7	1
2					SALARY=\$102,400						2
3											3
4											4
5	HELEN LACEK	MEMBER	ADMIN.		INNOVATIVE MGT	see	attached	mngmnt fees	11,000	17-3	5
6					SALARY=\$134,076			SALARY	19,088	17-7	6
7	DONNA ATKIN	MEMBER	ADMIN.	30.00	I H MANAGEMEN	see	attached	SALARY	8,884	17-7	7
8					SALARY=\$62,400						8
9	JOEL ATKIN	MEMBER	ADMIN	70.00	I H MANAGEMEN	see	attached	mngmnt fees	14,522	17-7	9
10					mngmntn fee=\$102,000						10
11	JAY ORLINSKY	CFO	BANKING, A/R,		INNOVATIVE MGT			SALARY	14,579	17-7	11
12			A/P,ADMIN.		SALARY=\$102,400						12
13								TOTAL	\$ 82,652		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: **01/01/2007** 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

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

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

1	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	\$ 26,742	\$ 14,579	1
2	17	ADMIN SAL.-LACEK	PATIENT DAYS	187,836	5	134,076	26,742	19,088	2
3	19	ACCOUNTING, DATA PROC.	PATIENT DAYS	187,836	5	4,200	26,742	598	3
4	21	OFFICE EXPENSE	PATIENT DAYS	187,836	5	58,180	26,742	8,283	4
5	21	CLERICAL SALARIES	PATIENT DAYS	187,836	5	211,938	26,742	30,173	5
6	27	PAY.TAXES & HEALTH INS	PATIENT DAYS	187,836	5	35,529	26,742	5,058	6
7	27	PAY.TAXES & HEALTH INS	DIRECT	1	1	16,971	1	16,971	7
8	39	THERAPY SALARIES	DIRECT	1	1	168,892	1	168,892	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					\$ 732,186	\$ 617,306	\$ 263,642	25

Facility Name & ID Number **PLAZA TERRACE**

0040386 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	\$ 26,742	\$ 14,579	1
2	17	SALARY- DONNA ATKIN	PER RESIDENT DAY	187,836	5	62,400	26,742	8,884	2
3	17	MANAGE. FEE- JOEL ATKIN	PER RESIDENT DAY	187,836	5	102,000	26,742	14,522	3
4	21	TELEPHONE	PER RESIDENT DAY	187,836	5	7,927	26,742	1,129	4
5	27	PAYROLL TAXES	PER RESIDENT DAY	187,836	5	13,600	26,742	1,936	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	\$ 41,050	25

Facility Name & ID Number **PLAZA TERRACE**

0040386 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 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	394,532	1	394,532	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					\$ 432,714	\$	\$ 432,714	25

Facility Name & ID Number

PLAZA TERRACE

0040386

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	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	premier bank (related party)		X	MORTGAGE	\$22,925.00	9/19/05	\$ 2,969,414	\$ 2,845,334	9/19/08	prime +1	\$ 269,961	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	PREMIER BABK		X	LINE OF CREDIT							18,620	6								
7	premier bank (related party)		X	LINE OF CREDIT	\$19,450.00	9/19/05	2,358,452	1,269,673	9/19/08	prime +1	124,571	7								
8												8								
9	TOTAL Facility Related				\$42,375.00		\$ 5,327,866	\$ 4,115,007			\$ 413,152	9								
B. Non-Facility Related*																				
10	IRS, IDR, ETC		X	LATE FEES								10								
11	IDPA		X	BED TAX							4,982	11								
12	COOK COUNTY TREASURY		X	R.E. TAX							4,182	12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ 9,164	14								
15	TOTALS (line 9+line14)						\$ 5,327,866	\$ 4,115,007			\$ 422,316	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.		\$	74,565	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.)		\$	79,789	2
3. Under or (over) accrual (line 2 minus line 1).		\$	5,224	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	79,789	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.		\$	85,013	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	53,783	8
	2003	55,460	9
	2004	58,112	10
	2005	74,565	11
	2006	79,789	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:

- 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:** 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 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 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>28-11-408-003-0000</u>	<u>NURSING HOME</u>	\$ <u>76,115.32</u>	\$ <u>76,115.32</u>
2. <u>28-11-408-004-0000</u>	<u>NURSING HOME</u>	\$ <u>579.87</u>	\$ <u>579.87</u>
3. <u>28-11-408-050-0000</u>	<u>NURSING HOME</u>	\$ <u>3,094.17</u>	\$ <u>3,094.17</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>79,789.36</u>	\$ <u>79,789.36</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.

Facility Name & ID Number PLAZA TERRACE

0040386 Report Period Beginning:

01/01/2007 Ending:

12/31/2007

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	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:

01/01/2007 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	92		1993		\$ 1,050,000	\$	27.5	\$ 38,182	\$ 38,182	\$ 559,623	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS		1993		5,150	164	31.5	164		2,409	9
10	VARIOUS		1993		5,006	128	39	128		1,854	10
11	AIR CONDITIONER		1994		19,602	503	39	503		6,811	11
12	ALARM		1994		9,612	246	39	246		3,373	12
13	WALLPAPER		1994		12,345	317	39	317		4,157	13
14	SPRINKLER		1993		3,530		39	91	91	1,183	14
15	IMPROVEMENTS - P.A. AUDIT		1993		13,002		39	333	333	4,329	15
16	CEILING - P.A. AUDIT		1993		13,500		39	346	346	4,498	16
17	NURSES STATION - P.A. AUDIT		1993		1,500		39	38	38	494	17
18	ASBESTOS CONTROL - P.A. AUDIT		1993		1,800		39	46	46	598	18
19	NEW ROOF		1996		26,844	688	39	688		7,941	19
20	NEW WINDOWS		1996		64,075	1,643	39	1,643		18,963	20
21	GENERATOR		1998		57,400	1,472	39	1,472		14,658	21
22	NEW PARKING LOT		1998		37,750	968	39	968		8,994	22
23	NEW GENERATOR		1998		50,100	1,285	39	1,285		10,976	23
24	KITCHEN ADDITION		1999		175,000	4,487	39	4,487		38,327	24
25	FRONT OFFICE REMODELING		1999		17,000	436	39	436		3,724	25
26	CONVERSION OF LAUNDRY TO BATHROOM		1999		12,000	308	39	308		2,631	26
27	HANDRAILS		1999		12,216	313	39	313		2,674	27
28	KITCHEN IMPROVEMENT		1999		39,948	1,024	39	1,024		8,747	28
29	TRANSFORMER		2001		12,100	310	39	310		1,925	29
30	DOOR		2003		5,241	191	27.5	191		867	30
31	HEATING UNIT		2003		10,000	364	27.5	364		1,653	31
32	ELECTRICAL WORK		2003		3,150	114	27.5	114		518	32
33	DOORS		2004		21,594	785	27.5	785		2,584	33
34	CARPETING		2004		13,324	767	5	1,332	565	5,328	34
35	DOORS		2006		11,734	427	27.5	232	(195)	464	35
36	HEATING UNITS		2006		2,804	102	27.5	55		110	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 CARPETING	2006	\$ 4,711	\$ 1,508	5	\$ 942	\$ (566)	\$ 1,884	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	\$ 18,550		\$ 57,343	\$ 38,840	\$ 722,297	70

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

Facility Name & ID Number **PLAZA TERRACE**

0040386

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	\$ 129,004	\$ 20,957	\$ 12,812	\$ (8,145)		\$ 42,138	71
72	Current Year Purchases	9,598	1,920	480	(1,440)		480	72
73	Fully Depreciated Assets	50,142					50,142	73
74								74
75	TOTALS	\$ 188,744	\$ 22,877	\$ 13,292	\$ (9,585)		\$ 92,760	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)	\$ 2,060,700	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 41,427	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 70,635	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 29,208	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 815,057	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: \$ 3,618 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			\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	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 \$ _____

13. _____ /2009 \$ _____

14. _____ /2010 \$ _____

* 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	\$		\$ 63,997	\$		\$ 63,997	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			416			416	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			35,533			35,533	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				77,194		77,194	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): med. Supply, radiology					792 59,648	5,310		792 64,958	13
14	TOTAL			\$		\$ 160,386	\$ 82,504		\$ 242,890	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: 01/01/2007

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	\$ 61,729	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 60,000)	914,582		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	35,429		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,011,740	\$	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	206,779		16
17	Accumulated Depreciation (book methods)	(311,508)		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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 505,942	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,517,682	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 625,152	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,001		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	32,441		30
31	Accrued Taxes Payable (excluding real estate taxes)	25,192		31
32	Accrued Real Estate Taxes(Sch.IX-B)	79,789		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO AFFILIATES	1,200,759		36
37	DUE TO INNOVATIVE HEALTHCARE	156,558		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,128,892	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	531,112		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)	\$ 531,112	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,660,004	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (1,142,322)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,517,682	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (420,323)	1
2	Restatements (describe):		2
3	2006 POST CLOSING ADJUSTMENTS	43,461	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (376,862)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(765,460)	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)	\$ (765,460)	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)	\$ (1,142,322)	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	\$ 3,222,700	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,222,700	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	19,576	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 19,576	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***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,242,276	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	670,703	31
32	Health Care	1,219,682	32
33	General Administration	1,157,743	33
	B. Capital Expense		
34	Ownership	666,342	34
	C. Ancillary Expense		
35	Special Cost Centers	242,890	35
36	Provider Participation Fee	50,376	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,007,736	40
41	Income before Income Taxes (line 30 minus line 40)**	(765,460)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (765,460)	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 DATE

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

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

Facility Name & ID Number **PLAZA TERRACE**

0040386

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	737	\$ 20,880	\$ 27.99	1
2	Assistant Director of Nursing				2
3	Registered Nurses	2,290	58,491	24.33	3
4	Licensed Practical Nurses	16,082	403,405	23.24	4
5	CNAs & Orderlies	48,874	467,967	9.10	5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	2,368	47,660	18.18	9
10	Activity Assistants	4,098	42,899	9.64	10
11	Social Service Workers				11
12	Dietician				12
13	Food Service Supervisor	412	10,874	21.75	13
14	Head Cook	7,086	92,258	11.64	14
15	Cook Helpers/Assistants	8,281	69,438	7.98	15
16	Dishwashers				16
17	Maintenance Workers	3,915	66,980	15.76	17
18	Housekeepers	14,477	139,763	9.18	18
19	Laundry				19
20	Administrator	2,165	80,069	30.19	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	7,158	114,354	14.77	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)	3,526	70,902	19.39	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	121,469	\$ 1,685,940 *	\$ 13.00	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 0	1-3	35
36	Medical Director	16,000	9-3	36
37	Medical Records Consultant	0	10-3	37
38	Nurse Consultant	0	10-3	38
39	Pharmacist Consultant	2,413	10-3	39
40	Physical Therapy Consultant	0	10a-3	40
41	Occupational Therapy Consultant	0	10a-3	41
42	Respiratory Therapy Consultant	0	10a-3	42
43	Speech Therapy Consultant	0	10a-3	43
44	Activity Consultant	0	11-3	44
45	Social Service Consultant	0	12-3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 18,413		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	
DAVIS,LATONYA	ADMINISTRATOR		\$ 80,069	Workers' Compensation Insurance	\$ 51,884	IDPH License Fee	\$	
			0	Unemployment Compensation Insurance	65,317	Advertising: Employee Recruitment	45	
			0	FICA Taxes	128,694	Health Care Worker Background Check	3,350	
				Employee Health Insurance	51,481	(Indicate # of checks performed)		
				Employee Meals	8,074	Patient Background Checks	78	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	0	
				EMPLOYEE BENEFITS - OTHER	15,739	MARKETING/ADV/PROMO	6,584	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	12,111	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOC		
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	0	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(6,584)	
						Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 80,069	TOTAL (agree to Schedule V, line 22, col.8)	\$ 321,189	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 15,584	
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			\$ 11,000			\$	Out-of-State Travel	\$
IH MANAGEMENT			177,000					
							In-State Travel	0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 188,000				Seminar Expense	5,735
C. Professional Services				TOTAL			Entertainment Expense	
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)	
HEALTH DATA SYSTEM	DATA PROCESSING		\$ 7,051					
HEALTH DATA SOLUTIONS	DATA PROCESSING		3,000					
MEDIFAX	DATA PROCESSING		487					
AMERICAN DATA	DATA PROCESSING		4,229					
KRUPNICK BOKOR, KAGDA	ACCOUNTING		24,950					
JAMES M. MAINZER	LEGAL FEES		283					
LARRY Y. SCHWARTZ	LEGAL FEES		1,077					
MEYER MEGANCE	LEGAL FEES		986					
TOHTZ COMPUTER	COMPUTER CONSULTANT		8,510					
RICHARD PEELO	MEDICARE CONSULTANT		3,750					
PERSONNEL PLANNERS	UC CONSULTANT		2,745					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 57,068					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PLAZA TERRACE# 0040386Report 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 \$7260
- (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. \$ 14,024 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. \$ 50,376
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. \$ 8,074 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