

		FOR OHF USE					

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**2001  
STATE OF ILLINOIS  
DEPARTMENT OF PUBLIC AID  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2001)**

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

**I. IDPH Facility ID Number:** 0037572

**Facility Name:** HILLCREST HEALTHCARE CENTER

**Address:** 777 DRAPER AVE JOLIET 60432  
Number City Zip Code

**County:** WILL

**Telephone Number:** ( 847 ) 647-1717 **Fax #** ( 847 ) 647-0222

**IDPA ID Number:** 36-3782789

**Date of Initial License for Current Owners:** 09/15/91

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

**In the event there are further questions about this report, please contact:**  
**Name:** BOB KAGDA **Telephone Number:** ( 847 ) 675-3585

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>SHERWIN I. RAY</u>	
	(Title) <u>PRESIDENT</u>	
<b>Paid Preparer</b>	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____
	(Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u>	
	(Firm Name & Address) <u>KRUPNICK BOKOR KAGDA &amp; BROOKS, LTD</u> <u>3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u>	
	(Telephone) <u>( 847 ) 675-3585</u> <b>Fax #</b> <u>( 847 ) 675-5777</u>	

**MAIL TO: OFFICE OF HEALTH FINANCE  
ILLINOIS DEPARTMENT OF PUBLIC AID  
201 S. Grand Avenue East  
Springfield, IL 62763-0001 Phone # (217) 782-1630**

Facility Name & ID Number HILLCREST HEALTHCARE CENTER# 0037572 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

## 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	<u>84</u>	Skilled (SNF)	<u>84</u>	<u>30,660</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>84</u>	Intermediate (ICF)	<u>84</u>	<u>30,660</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>168</u>	TOTALS	<u>168</u>	<u>61,320</u>	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				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			<u>1,154</u>	<u>1,154</u>	8
9	SNF/PED					9
10	ICF	<u>42,532</u>	<u>1,157</u>		<u>43,689</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>42,532</u>	<u>1,157</u>	<u>1,154</u>	<u>44,843</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.13%

D. How many bed-hold days during this year were paid by Public Aid?

914 (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)

NONEF. Does the facility maintain a daily midnight census? YES

G. Do pages 3 &amp; 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 09/15/91

J. Was the facility purchased or leased after January 1, 1978?

YES  Date 09/15/91 NO 

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter numberof beds certified 18 and days of care provided 1,154Medicare Intermediary ADMINISTAR

## IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 12/31/01 Fiscal Year: 12/31/01

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

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	159,199	18,951	9,181	187,331		187,331	135	187,466		1
2	Food Purchase		181,040		181,040	(13,469)	167,571	(1,392)	166,179		2
3	Housekeeping	127,733	29,900	0	157,633		157,633	0	157,633		3
4	Laundry	58,946	10,787	515	70,248		70,248	0	70,248		4
5	Heat and Other Utilities			109,119	109,119		109,119	500	109,619		5
6	Maintenance	44,269	46,978	69,962	161,209		161,209	4,502	165,711		6
7	Other (specify):*			12,504	12,504		12,504	0	12,504		7
8	<b>TOTAL General Services</b>	390,147	287,656	201,281	879,084	(13,469)	865,615	3,745	869,360		8
	<b>B. Health Care and Programs</b>										
9	Medical Director	0		13,300	13,300		13,300	0	13,300		9
10	Nursing and Medical Records	1,283,622	49,523	5,212	1,338,357		1,338,357	22,224	1,360,581		10
10a	Therapy	88,219	1,609	20,524	110,352		110,352	8,609	118,961		10a
11	Activities	65,195	14,008	0	79,203		79,203	0	79,203		11
12	Social Services	206,326		1,589	207,915		207,915	0	207,915		12
13	Nurse Aide Training			0	0		0	0	0		13
14	Program Transportation			0	0		0	0	0		14
15	Other (specify):*			0	0		0	0	0		15
16	<b>TOTAL Health Care and Programs</b>	1,643,362	65,140	40,625	1,749,127	0	1,749,127	30,833	1,779,960		16
	<b>C. General Administration</b>										
17	Administrative	200,643		240,000	440,643		440,643	(134,353)	306,290		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			283,529	283,529		283,529	(176,354)	107,175		19
20	Dues, Fees, Subscriptions & Promotions			21,304	21,304		21,304	(3,620)	17,684		20
21	Clerical & General Office Expenses	151,968	13,309	160,291	325,568		325,568	(51,015)	274,553		21
22	Employee Benefits & Payroll Taxes			378,508	378,508	13,469	391,977	0	391,977		22
23	Inservice Training & Education			3,134	3,134		3,134	432	3,566		23
24	Travel and Seminar			186	186		186	456	642		24
25	Other Admin. Staff Transportation			8,947	8,947		8,947	2,078	11,025		25
26	Insurance-Prop.Liab.Malpractice			132,390	132,390		132,390	4,033	136,423		26
27	Other (specify):*			0	0		0	34,325	34,325		27
28	<b>TOTAL General Administration</b>	352,611	13,309	1,228,289	1,594,209	13,469	1,607,678	(324,018)	1,283,660		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,386,120	366,105	1,470,195	4,222,420	0	4,222,420	(289,440)	3,932,980		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 (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			36,252	36,252		36,252	700	36,952			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			61,739	61,739		61,739	15,239	76,978			32
33	Real Estate Taxes			67,603	67,603		67,603	0	67,603			33
34	Rent-Facility & Grounds			724,296	724,296		724,296	5,859	730,155			34
35	Rent-Equipment & Vehicles			38,743	38,743		38,743	6,235	44,978			35
36	Other (specify):*			0	0		0	0	0			36
37	<b>TOTAL Ownership</b>			928,633	928,633	0	928,633	28,033	956,666			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		78,792	14,697	93,489		93,489	(3,978)	89,511			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			91,980	91,980		91,980	0	91,980			42
43	Other (specify):*				0		0	0	0			43
44	<b>TOTAL Special Cost Centers</b>	0	78,792	106,677	185,469	0	185,469	(3,978)	181,491			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	2,386,120	444,897	2,505,505	5,336,522	0	5,336,522	(265,385)	5,071,137			45

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

Facility Name & ID Number HILLCREST HEALTHCARE CENTER

# 0037572

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(8,575)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,392)	2		13
14	Non-Care Related Interest	(224)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(100)	20		17
18	Fines and Penalties	(18,287)	21		18
19	Entertainment				19
20	Contributions	(2,512)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,614)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(342)	20		28
29	Other-Attach Schedule <u>SEE PAGE 5A</u>	(5,222)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (41,268)		\$ 0	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(224,117)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (224,117)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (265,385)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

STATE OF ILLINOIS  
HILLCREST HEALTHCARE CENTER

ID# 0037572

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	DEFERRED MAINTENANCE	\$ (5,222)	6	1
2				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	<b>Total</b>	(5,222)		48
49				49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number HILLCREST HEALTHCARE CENTER

# 0037572

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	135	0	0	0	0	0	0	0	0	0	135	1
2	Food Purchase	(1,392)	0	0	0	0	0	0	0	0	0	0	(1,392)	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	500	0	0	0	0	0	0	0	0	0	500	5
6	Maintenance	(5,222)	9,724	0	0	0	0	0	0	0	0	0	4,502	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(6,614)</b>	<b>10,359</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>3,745</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	22,224	0	0	0	0	0	0	0	0	0	22,224	10
10a	Therapy	0	8,781	(172)	0	0	0	0	0	0	0	0	8,609	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	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>31,005</b>	<b>(172)</b>	<b>0</b>	<b>30,833</b>	<b>16</b>							
	<b>C. General Administration</b>													
17	Administrative	0	(134,353)	0	0	0	0	0	0	0	0	0	(134,353)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(176,354)	0	0	0	0	0	0	0	0	0	(176,354)	19
20	Fees, Subscriptions & Promotions	(7,568)	0	3,948	0	0	0	0	0	0	0	0	(3,620)	20
21	Clerical & General Office Expenses	(18,287)	(100,800)	68,072	0	0	0	0	0	0	0	0	(51,015)	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	432	0	0	0	0	0	0	0	0	432	23
24	Travel and Seminar	0	0	456	0	0	0	0	0	0	0	0	456	24
25	Other Admin. Staff Transportation	0	0	2,078	0	0	0	0	0	0	0	0	2,078	25
26	Insurance-Prop.Liab.Malpractice	0	0	4,033	0	0	0	0	0	0	0	0	4,033	26
27	Other (specify):*	0	0	34,325	0	0	0	0	0	0	0	0	34,325	27
28	<b>TOTAL General Administration</b>	<b>(25,855)</b>	<b>(411,507)</b>	<b>113,344</b>	<b>0</b>	<b>(324,018)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(32,469)</b>	<b>(370,143)</b>	<b>113,172</b>	<b>0</b>	<b>(289,440)</b>	<b>29</b>							

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number HILLCREST HEALTHCARE CENTER# 0037572

Report Period Beginning:

01/01/2001 Ending:

12/31/2001

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	<b>D. Ownership</b>												
30	Depreciation	(8,575)	0	9,275	0	0	0	0	0	0	0	0	700 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(224)	0	15,463	0	0	0	0	0	0	0	0	15,239 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	5,859	0	0	0	0	0	0	0	0	5,859 34
35	Rent-Equipment & Vehicles	0	0	6,235	0	0	0	0	0	0	0	0	6,235 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	<b>TOTAL Ownership</b>	<b>(8,799)</b>	<b>0</b>	<b>36,832</b>	<b>0</b>	<b>28,033 37</b>							
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	(3,978)	0	0	0	0	0	0	0	0	(3,978) 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>(3,978)</b>	<b>0</b>	<b>(3,978) 44</b>							
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(41,268)</b>	<b>(370,143)</b>	<b>146,026</b>	<b>0</b>	<b>(265,385) 45</b>							

**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
				CAREPLUS MGMT	NILES	MGMT/CLERICAL
				CAREPLUS REHABILITATIVE SERVICES		
SEE ATTACHED SCHEDULES					NILES	THERAPY

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	17	MANAGEMENT FEES	\$ 180,000	CAREPLUS MGMT INC		\$ (180,000)	1
2	V	19	ADMIN. CONSULTANT FEES	168,000	" "		(168,000)	2
3	V	19	DATA PROCESSING FEES	13,200	" "		(13,200)	3
4	V	21	CLERICAL FEES	100,800	" "		(100,800)	4
5	V	1	DIETARY CONSULTANT FEES	7,200	" "		(7,200)	5
6	V	1	DIETARY SALARIES		" "	7,335	7,335	6
7	V	5	ELECTRICITY		" "	500	500	7
8	V	6	REPAIRS		" "	285	285	8
9	V	6	MAINTENANCE SALARIES		" "	9,439	9,439	9
10	V	10	NURSING		" "	22,224	22,224	10
11	V	10a	THERAPY SALARIES/SUPPLIES		" "	8,781	8,781	11
12	V	17	ADMIN SALARIES		" "	45,647	45,647	12
13	V	19	PROFESSIONAL FEES		" "	4,846	4,846	13
14	Total		\$ 469,200			\$ 99,057	\$ * (370,143)	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	20 DUES/LICENSES/WANT ADS	\$	CAREPLUS MGMT INC		\$ 3,948	\$ 3,948	15
16	V	21 OFFICE SALARIES/EXPENSES		" "		68,072	68,072	16
17	V	23 SEMINARS		" "		432	432	17
18	V	24 TRAVEL		" "		456	456	18
19	V	25 TRANSPORTATION		" "		2,078	2,078	19
20	V	26 INSURANCE		" "		4,033	4,033	20
21	V	27 EMPLOYEE BENEFITS		" "		34,325	34,325	21
22	V	30 SL DEPRECIATION		" "		9,275	9,275	22
23	V	32 INTEREST		" "		15,463	15,463	23
24	V	34 OFFICE RENT		" "		5,859	5,859	24
25	V	35 EQUIP RENT/AUTO LEASE		" "		6,235	6,235	25
26	V							26
27	V							27
28	V							28
29	V	10a THERAPY SERVICES	19,592	CAREPLUS REHABILITATIVE SERVICES		19,420	(172)	29
30	V	39 ANCILLARY THERAPY	14,036	" "		10,058	(3,978)	30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 33,628			\$ 179,654	\$ * 146,026	39

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

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

## 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	CAREPLUS MGMT ALLOCATIONS:								\$		1
2	SHERWIN RAY	PRESIDENT	ADMIN/FINANCE	34.67	SEE ATTACHED	4.4	7.39	SALARY	13,676	17-7	2
3	JAKOB BAKST	DIR OPERAT'NS	ADMIN/CONS.	34.67	SCHEDULES	4.4	7.39	" "	13,676	17-7	3
4	JOE ZIMMERMAN	CFO	CLERICAL	0.60	" "	4.4	7.39	" "	8,380	21-7	4
5	JANICE CLAFFORD	CONTROLLER	CLERICAL	0.60	" "	4.4	7.39	" "	2,926	21-7	5
6	ROMY MACASAET	RN CONSULT.	NURSING	0.60	" "	4.4	7.39	" "	6,539	10-7	6
7	JAMEE O'BRIEN	REGIONAL DIR.	ADMIN	0.60	" "	4.4	7.39	" "	7,627	17-7	7
8	TAMMY ORR	RN CONSULT.	NURSING	0.60	" "	4.4	7.39	" "	6,264	10-7	8
9	ROSLYN INDICH	BKKP	CLERICAL	2.38	" "	4.4	7.39	" "	3,332	21-7	9
10											10
11	ERIC ROTHNER (HUNTER MGMT LLC)		CONSULTING	21.15	" "	0.27	0.00	MGMT FEES	60,000	17-3	11
12											12
13								TOTAL	\$ 122,420		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 HILLCREST HEALTHCARE CENTER

# 0037572

Report Period Beginning: 01/01/2001

Ending: 2/31/2001

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 CAREPLUS MANAGEMENT INC  
 Street Address 5940 W TOUHY  
 City / State / Zip Code NILES 60714  
 Phone Number ( 847) 647-1717  
 Fax Number ( 847) 647-0222

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	1	DIETARY SALARIES	506,586	11 HOMES	\$ 83,890	\$ 83,890	44,843	\$ 7,426	1
2	5	ELECTRICITY	606,625	15 HOMES	6,767		44,843	500	2
3	6	REPAIRS	606,625	15 HOMES	3,858		44,843	285	3
4	6	MAINTENANCE SALARIES	606,625	15 HOMES	127,691	127,691	44,843	9,439	4
5	10	NURSING	606,625	15 HOMES	300,646	300,646	44,843	22,224	5
6	10a	THERAPY SALARIES	570,238	13 HOMES	111,658	96,375	44,843	8,781	6
7	17	ADMIN SALARIES	606,625	15 HOMES	617,499	617,499	44,843	45,647	7
8	19	PROFESSIONAL FEES	606,625	15 HOMES	65,550		44,843	4,846	8
9	20	DUES/LICENSES/WANT ADS	606,625	15 HOMES	53,408		44,843	3,948	9
10	21	OFFICE SALARIES/EXPENSES	606,625	15 HOMES	920,855	677,141	44,843	68,072	10
11	23	SEMINARS	606,625	15 HOMES	5,849		44,843	432	11
12	24	TRAVEL	606,625	15 HOMES	6,170		44,843	456	12
13	25	TRANSPORTATION	606,625	15 HOMES	28,114		44,843	2,078	13
14	26	INSURANCE	606,625	15 HOMES	54,564		44,843	4,033	14
15	27	EMPLOYEE BENEFITS	606,625	15 HOMES	464,335		44,843	34,325	15
16	30	SL DEPRECIATION	606,625	15 HOMES	125,471		44,843	9,275	16
17	32	INTEREST	606,625	15 HOMES	209,175		44,843	15,463	17
18	34	OFFICE RENT	606,625	15 HOMES	79,265		44,843	5,859	18
19	35	EQUIP RENT/AUTO LEASE	606,625	15 HOMES	84,343		44,843	6,235	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,349,108	\$ 1,903,242		\$ 249,324	25

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

**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		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			
	<b>A. Directly Facility Related</b>																
	<b>Long-Term</b>																
1	<b>CAREPLUS MANAGEMENT ALLOCATION: LOC, ETC</b>																
2																	
3																	
4	<b>CAREPLUS MGMT - CIB BK</b>	<b>X</b>		<b>CAPL IMPR LOAN FEES</b>	<b>5 YR AMORT</b>	<b>2/23/01</b>	<b>2,250</b>	<b>1,875</b>	<b>1/23/06</b>		<b>375</b>						
5	<b>CAREPLUS MGMT - CIB BK</b>	<b>X</b>		<b>CAPITAL IMPROVEMENT</b>	<b>\$9,478.71</b>	<b>2/23/01</b>	<b>450,000</b>	<b>384,345</b>	<b>1/23/06</b>	<b>PRIME+</b>	<b>29,132</b>						
	<b>Working Capital</b>																
6	<b>CAREPLUS MGMT INC</b>	<b>X</b>		<b>WORKING CAPITAL</b>	<b>DEMAND</b>	<b>04/95</b>	<b>1,925,000</b>	<b>570,000</b>		<b>PRIME+</b>	<b>27,740</b>						
7	<b>INSURANCE FINANCING</b>		<b>X</b>	<b>INSUR. FINANCE</b>							<b>4,268</b>						
8																	
9	<b>TOTAL Facility Related</b>				<b>\$9,478.71</b>		<b>\$ 2,377,250</b>	<b>\$ 956,220</b>			<b>\$ 76,978</b>						
	<b>B. Non-Facility Related*</b>																
10	<b>IRS, IDR, ETC</b>		<b>X</b>	<b>LATE FEES</b>							<b>224</b>						
11																	
12																	
13																	
14	<b>TOTAL Non-Facility Related</b>						<b>\$ 0</b>	<b>\$ 0</b>			<b>\$ 224</b>						
15	<b>TOTALS (line 9+line14)</b>						<b>\$ 2,377,250</b>	<b>\$ 956,220</b>			<b>\$ 77,202</b>						

\* 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 2000 report.	\$	<b>61,850</b>	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.)	\$	<b>64,403</b>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>2,553</b>	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>65,050</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		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. <b>TOTAL REFUND \$ _____ For 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<b>67,603</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1996	<b>57,091</b>	8
	1997	<b>58,191</b>	9
	1998	<b>58,377</b>	10
	1999	<b>61,241</b>	11
	2000	<b>64,403</b>	12

<b>FOR OHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2000	\$	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 2000 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: 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 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,

**2000 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME HILLCREST HEALTHCARE CENTER COUNTY WILL

FACILITY IDPH LICENSE NUMBER 0037572

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

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

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2000

(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. 07-11-101-003-0000	NURSING HOME	\$ 64,402.74	\$ 64,402.74
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>64,402.74</u>	\$ <u>64,402.74</u>

**B. Real Estate Tax Cost Allocation:**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct 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 hom (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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number HILLCREST HEALTHCARE CENTER

# 0037572 Report Period Beginning:

01/01/2001 Ending: 12/31/2001

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 23,039 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 3

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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>NURSING HOME</u>	<u>132,928</u>		\$	1
2					2
3	<b>TOTALS</b>	<u>132,928</u>		\$ <u>0</u>	3

Facility Name & ID Number **HILLCREST HEALTHCARE CENTER**

# **0037572**

Report Period Beginning:

**01/01/2001**

Ending:

**12/31/2001**

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		LEASEHOLD IMPROVEMENTS	1991		6,230	198	31.5	198		2,014	9
10		LEASEHOLD IMPROVEMENTS	1992		48,072	1,525	31.5	1,526	1	14,497	10
11		LEASEHOLD IMPROVEMENTS	1993		33,291	981	31.5	1,057	76	8,984	11
12		LEASEHOLD IMPROVEMENTS	1994		10,172	261	39	261		1,925	12
13		ROOF REPAIR	1995		5,221	134	39	134		843	13
14		CONDENSING UNITS	1996		3,924	101	39	101		568	14
15		CEILING TILES	1996		1,334	34	39	34		186	15
16		ROOF REPAIR	1996		8,079	207	39	207		1,113	16
17		DOORS	1997		1,078	28	39	28		127	17
18		WINDOWS & ROOF VENTILATOR	1997		3,572	92	39	92		372	18
19		WINDOWS	1998		12,100	309	39	310	1	1,117	19
20		ROOF REPAIRS/DOORS/ELEC. REPAIRS/LOT LIGHTS	1998		23,693	607	39	607		2,161	20
21		WALLCOVER/RAILS/NURSE STNS/WINDOW TREATMENTS	1998		155,436	3,985	39	3,985		13,852	21
22		WINDOWS/DECORATING/CEILING TILE/ROOF REPAIR	1999		70,751	1,814	39	1,814		4,580	22
23		WINDOWS/FLOORING/DOOR	2000		12,169	442	27.5	442		724	23
24		CARPETING	2000		2,088	511	10	209	(302)	313	24
25		DOORS/ELEVATOR REPAIRS/SECURITY SYSTEM UPGRADE	2001		42,268	1,105	27.5	1,105		1,105	25
26		FENCE	2001		10,361	345	15	345		345	26
27		ROOF REPAIRS/CEILING TILE/FIRE DAMPERS/LIGHTING	2001		43,148	303	27.5	303		303	27
28											28
29											29
30											30
31											31
32											32
33											33
34		RELATED PARTY ALLOCATION - CAREPLUS MGMT				87		87			34
35											35
36											36

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

See Page 12A, Line 70 for total

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

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	<b>TOTAL (lines 4 thru 69)</b>	\$	492,987	\$	13,069	\$	12,845	\$	(224)	\$	55,129	70

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

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

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	\$ 172,125	\$ 21,664	\$ 14,473	\$ (7,191)	7-15 YRS	\$ 56,224	71
72	Current Year Purchases	11,236	1,606	446	(1,160)	10-15 YRS	446	72
73	Fully Depreciated Assets	35,500			0	5-7 YRS	35,500	73
74	<b>** RELATED PARTY - ALLOCATED SL DEPN: CAREPLUS MGMT, 9,188</b>		9,188	9,188	0			74
75	TOTALS	\$ 218,861	\$ 32,458	\$ 24,107	\$ (8,351)		\$ 92,170	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	0		\$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 0	\$ 0	\$ 0	0		\$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 711,848	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 45,527	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 36,952	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (8,575)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 147,299	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: DRAPER PLAZA

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 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		168	9/15/91	\$ 724,296	15		3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>		168		\$ 724,296			7

10. Effective dates of current rental agreement:

Beginning 9/15/91

Ending 9/15/16

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

Fiscal Year Ending Annual Rent

12. 12/31/2002 \$ \_\_\_\_\_

13. 12/31/2003 \$ \_\_\_\_\_

14. 12/31/2004 \$ \_\_\_\_\_

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: \$ 30,322 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>ACTIVITY/HSKP/</u>		\$ _____	\$ _____	17
18	<u>MAINT</u>	<u>FACILITY VAN</u>	<u>620+</u>	<u>8,421</u>	18
19					19
20					20
21	<b>TOTAL</b>		\$ _____	\$ 8,421	21

\* 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.

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

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

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

<p>1. HAVE YOU TRAINED AIDES 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><u>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</u></p>	<p>2. CLASSROOM PORTION:</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 AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	---	--

**B. EXPENSES**

ALLOCATION OF COSTS (d)

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

**C. CONTRACTUAL INCOME**

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

\$ \_\_\_\_\_

**D. NUMBER OF AIDES TRAINED**

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide 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 aides.

(e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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	\$		\$ 8,366	\$		\$ 8,366	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			81			81	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			5,590			5,590	4
5	Physician Care		visits							5
6	Dental Care	39-3	visits			660			660	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				69,058		69,058	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39-2					4,098		4,098	12
13	MED.SUPPLIES/LAB/RENTALS Other (specify):	39-2					5,636		5,636	13
14	TOTAL			\$		\$ 14,697	\$ 78,792		\$ 93,489	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 nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number HILLCREST HEALTHCARE CENTER# 0037572Report Period Beginning: 01/01/2001

Ending:

12/31/2001

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2001 (last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,218,258		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	107,191		6
7	Other Prepaid Expenses	9,209		7
8	Accounts Receivable (owners or related parties)	25,000		8
9	Other(specify): <u>R.E.TAX ESCROW</u>	60,090		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,419,748	\$ 0	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	492,987		15
16	Equipment, at Historical Cost	218,861		16
17	Accumulated Depreciation (book methods)	(214,175)		17
18	Deferred Charges	1,875		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 499,548	\$ 0	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,919,296	\$ 0	25

		1	2	
		Operating	After	
			Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 635,614	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	570,000		29
30	Accrued Salaries Payable	89,171		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,673		31
32	Accrued Real Estate Taxes(Sch.IX-B)	65,050		32
33	Accrued Interest Payable	12,789		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
36	<b>Other Current Liabilities(specify):</b>			36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,378,297	\$ 0	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	384,345		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
43	<b>Other Long-Term Liabilities(specify):</b>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 384,345	\$ 0	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,762,642	\$ 0	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 156,654	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,919,296	\$ 0	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>486,476</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>2000 IL REPLACEMENT TAX</b>	<b>(6,108)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>480,368</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(323,714)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(323,714)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>0</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>156,654</b>	<b>24</b> *

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

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,037,163	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,037,163	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	8,617	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 8,617	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 0	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 0	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 0	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,045,780	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	879,084	31
32	Health Care	1,749,127	32
33	General Administration	1,594,209	33
<b>B. Capital Expense</b>			
34	Ownership	928,633	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	93,489	35
36	Provider Participation Fee	91,980	36
<b>D. Other Expenses (specify):</b>			
37	<b>OUT OF PERIOD EXPENSES</b>	32,972	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,369,494	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(323,714)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (323,714)	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.

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

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

Facility Name & ID Number **HILLCREST HEALTHCARE CENTER**

# **0037572**

Report Period Beginning: **01/01/2001**

Ending: **12/31/2001**

**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	3,483	3,633	\$ 96,314	\$ 26.51	1
2	Assistant Director of Nursing	199	208	5,517	26.52	2
3	Registered Nurses	18,804	20,468	435,983	21.30	3
4	Licensed Practical Nurses	14,992	15,853	289,525	18.26	4
5	Nurse Aides & Orderlies	44,373	48,980	436,471	8.91	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,245	8,353	88,219	10.56	8
9	Activity Director	2,464	2,613	41,478	15.87	9
10	Activity Assistants	3,521	3,752	23,717	6.32	10
11	Social Service Workers	14,674	15,660	206,326	13.18	11
12	Dietician					12
13	Food Service Supervisor	2,016	2,109	30,987	14.69	13
14	Head Cook	5,890	6,552	48,049	7.33	14
15	Cook Helpers/Assistants	12,818	13,985	80,163	5.73	15
16	Dishwashers					16
17	Maintenance Workers	4,041	4,214	44,269	10.51	17
18	Housekeepers	19,020	20,650	127,733	6.19	18
19	Laundry	7,536	8,611	58,946	6.85	19
20	Administrator	1,890	2,079	68,175	32.79	20
21	Assistant Administrator	5,012	5,187	132,468	25.54	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,477	8,061	151,968	18.85	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	1,737	1,955	19,812	10.13	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	177,192	192,923	\$ 2,386,120 *	\$ 12.37	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	\$ 7,200	1-3	35
36	Medical Director	O	13,300	9-3	36
37	Medical Records Consultant	N	2,064	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	1,848	10-3	39
40	Physical Therapy Consultant	L	5,400	10a-3	40
41	Occupational Therapy Consultant	Y	5,400	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	1,589	12-3	45
46	Other(specify)	S			46
47	PSYCHIATRIC		1,300	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 38,101		49

**C. CONTRACT NURSES**

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



**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).**  
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY1998	6 FY1999	7 FY2000	8 FY2001	9 FY2002	10 FY2003	11 FY2004	12 FY2005	13 FY2006
1	PAINT/DECORATING	1998	\$ 4,043	3	\$ 674	\$ 1,348	\$ 1,348	\$ 673	\$	\$	\$	\$	\$
2	PAINT/DECORATING	2001	7,075	3				1,180	2,358	2,358	1,179		
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 11,118		\$ 674	\$ 1,348	\$ 1,348	\$ 1,853	\$ 2,358	\$ 2,358	\$ 1,179	\$	\$

Facility Name &amp; ID Number HILLCREST HEALTHCARE CENTER

## 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 COUNCIL LONG TERM CARE 7115
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (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. \$ 0 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 of Public Aid during this cost report period. \$ 91,980  
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 of Public Aid, 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. \$ 13,469 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.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	7,200
	REPAIRS & MAINTENANCE	1,981
		0
		9,181
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	515
		0
		515
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	12,140
	ELECTRICITY	60,970
	WATER	35,454
	CABLE TV - LOBBY	555
		0
		109,119
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	5,506
	PAINTING & DECORATING	7,075
	BUILDING REPAIRS	12,621
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	24,563
	ELEVATOR MAINTENANCE & REPAIR	11,209
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,375
	FIRE SERVICE	5,613
		0
		0
		0
		69,962
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	12,504
	SECURITY SERVICE	0
		12,504
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	13,300
		13,300

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B -2	0
	RESTORATIVE NURSING CONSULTAN XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	2,064
	PHARMACY CONSULTANT XVIII B 39-2	1,848
	UTILIZATION REVIEW FEES XVIII B -2	0
	PHYSICIANS XVIII B -2	0
	PSYCHIATRIC XVIII B 47-2	1,300
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		5,212
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	1,377
	SPEECH THERAPY SERVICES	162
	OCCUPATIONAL THERAPY SERVICES	2,160
	THERAPY CONTRACT SERVICES	6,025
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	5,400
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	5,400
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		20,524
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
		0
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	1,589
		0
		1,589
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	0
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	240,000
18	<b>DIRECTORS FEES</b>	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	15,600
	ADMINISTRATIVE CONSULTANTS XIX C	168,000
	PROFESSIONAL FEES XIX C	99,929
		0
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	283,529
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	4,614
	EMPLOYEE WANT ADS XIX F	7,087
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	5,615
	LICENSES & PERMITS XIX F	1,034
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	342
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	100
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	2,512
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	21,304
	BANK CHARGES	0
	EQUIPMENT REPAIR & MAINTENANCE	9,764
	OUTSIDE CLERICAL SERVICES	100,800
	PENALTIES / OVERDRAFT CHARGES VI 18	18,287
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	323
	TELEPHONE	29,883
	MESSENGER SERVICE	1,234
		0
		160,291

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	180,080
	UNEMPLOYMENT COMPENSATION XIX D	19,207
	WORKERS COMPENSATION INSURANC XIX D	46,432
	HOSPITALIZATION INSURANCE XIX D	102,742
	EMPLOYEE BENEFITS - OTHER XIX D	2,402
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	27,645
	CHICAGO HEAD TAX XIX D	0
		378,508
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	3,134
		3,134
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	186
		0
		0
		186
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	8,947
		8,947
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	132,390
		132,390
27	<b>OTHER</b>	
	BAD DEBTS VI 24	0
		0
		0

GRAND TOTAL COLUMN 3 OTHER

1,470,195

HILLCREST HEALTHCARE CENTER  
 EMPLOYEE MEAL RECLASSIFICATION  
 12/31/2001

TOTAL FOOD PURCHASE	181,040	PATIENT MEALS	134529
LESS SALES TAX	(1,392)	ADD EMPLOYEE MEALS	10950
	-----		-----
NET FOOD	179,648	TOTAL MEALS/YEAR	145479
TOTAL PATIENT CENSUS	44,843	NET FOOD	179648
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	145479
	-----		
TOTAL PATIENT MEALS	134529	COST PER MEAL	1.23
		TIME EMPLOYEE MEALS	10950
ADD # EMPLOYEE MEALS/DAY	30		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	13469
	-----		=====
TOTAL EMPLOYEE MEALS	10950		