

		FOR OHF USE				

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**2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)**

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.

<p>I. IDPH Facility ID Number: <u>0045302</u></p> <p>Facility Name: <u>Hillview Health Care Center</u></p> <p>Address: <u>512 N. 11th Street</u> <u>Vienna</u> <u>62995</u> Number City Zip Code</p> <p>County: <u>Johnson</u></p> <p>Telephone Number: <u>618-658-2951</u> Fax # <u>618-658-3518</u></p> <p>IDPA ID Number: <u>431921924001</u></p> <p>Date of Initial License for Current Owners: <u>4-13-2001</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact Name: <u>Buford L. Snipes</u> Telephone Number: <u>573-481-9858</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input 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	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>Jan. 1, 2003</u> to <u>Dec. 31, 2003</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1129 678 1266 829">Officer or Administrator of Provider</td> <td data-bbox="1266 678 1890 748">(Signed) _____ (Date) <u>03/31/2004</u> (Type or Print Name) <u>James C. Lincoln</u></td> </tr> <tr> <td data-bbox="1129 829 1266 1045">Paid Preparer</td> <td data-bbox="1266 829 1890 1045">(Title) <u>President</u> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (____) _____ Fax # (____) _____</td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) <u>03/31/2004</u> (Type or Print Name) <u>James C. Lincoln</u>	Paid Preparer	(Title) <u>President</u> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (____) _____ Fax # (____) _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input 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																											
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																											
	<input type="checkbox"/> "Sub-S" Corp.																												
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Officer or Administrator of Provider	(Signed) _____ (Date) <u>03/31/2004</u> (Type or Print Name) <u>James C. Lincoln</u>																												
Paid Preparer	(Title) <u>President</u> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (____) _____ Fax # (____) _____																												

Facility Name & ID Number Hillview Health Care Center

0045302 Report Period Beginning: Jan. 1, 2003 Ending: Dec. 31, 2003

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	71	Skilled (SNF)	71	25,915	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	71	TOTALS	71	25,915	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	12,874	4,315	2,975	20,164	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,874	4,315	2,975	20,164	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4) 77.81%

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

5 (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 4-13-2001

J. Was the facility purchased or leased after January 1, 1978?
YES Date 4-13-2001 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 71 and days of care provided 1,945

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year YES NO

Tax Year: _____ Fiscal Year: _____

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

STATE OF ILLINOIS

Page 3

Facility Name & ID Number

Hillview Health Care Center

0045302

Report Period Beginning:

Jan. 1, 2003

Ending:

Dec. 31, 2003

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
1	A. General Services										
1	Dietary	112,539	7,640	4,349	124,528		124,528	12	124,540		1
2	Food Purchase		80,807		80,807		80,807	(564)	80,243		2
3	Housekeeping	46,057	9,238	15,016	70,311		70,311	2,810	73,121		3
4	Laundry	27,856	9,855		37,711		37,711	17	37,728		4
5	Heat and Other Utilities			48,841	48,841		48,841		48,841		5
6	Maintenance	27,890	2,065	17,630	47,585		47,585	203	47,788		6
7	Other (specify):*										7
8	TOTAL General Services	214,342	109,605	85,836	409,783		409,783	2,478	412,261		8
	B. Health Care and Programs										
9	Medical Director			5,400	5,400		5,400		5,400		9
10	Nursing and Medical Records	579,131	77,492	7,284	663,907		663,907	(50,665)	613,242		10
10a	Therapy			91,229	91,229		91,229		91,229		10a
11	Activities	18,827	2,753		21,580		21,580		21,580		11
12	Social Services	17,586	39	1,648	19,273		19,273		19,273		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	615,544	80,284	105,561	801,389		801,389	(50,665)	750,724		16
	C. General Administration										
17	Administrative	48,340		101,281	149,621	9,300	158,921	(64,295)	94,626		17
18	Directors Fees										18
19	Professional Services			16,598	16,598	(5,100)	11,498		11,498		19
20	Dues, Fees, Subscriptions & Promotion			5,224	5,224	598	5,822	(1,948)	3,874		20
21	Clerical & General Office Expense	23,899	20,253		44,152	(4,200)	39,952	(29)	39,923		21
22	Employee Benefits & Payroll Tax			147,405	147,405	(598)	146,807		146,807		22
23	Inservice Training & Education										23
24	Travel and Seminars			1,911	1,911		1,911		1,911		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			29,424	29,424		29,424		29,424		26
27	Other (specify):*			8,298	8,298		8,298	(7,225)	1,073		27
28	TOTAL General Administration	72,239	20,253	310,141	402,633		402,633	(73,497)	329,136		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	902,125	210,142	501,538	1,613,805		1,613,805	(121,684)	1,492,121		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.

Facility Name & ID Number Hillview Health Care Center

#0045302

Report Period Beginning: Jan. 1, 2003 Ending: Dec. 31, 2003

Dec. 31, 2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			593	593	593		593				30
31	Amortization of Pre-Op. & Org											31
32	Interest											32
33	Real Estate Taxes			21,525	21,525	21,525		21,525				33
34	Rent-Facility & Grounds			132,000	132,000	132,000	9,890	141,890				34
35	Rent-Equipment & Vehicle:			8,064	8,064	8,064	(680)	7,384				35
36	Other (specify): ^a											36
37	TOTAL Ownership			162,182	162,182	162,182	9,210	171,392				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportatior											38
39	Ancillary Service Center:			725	725	725	(69)	656				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shop:											41
42	Provider Participation Fee			29,501	29,501	29,501		29,501				42
43	Other (specify): ^a			3,505	3,505	3,505	(3,505)					43
44	TOTAL Special Cost Centers			33,731	33,731	33,731	(3,574)	30,157				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	902,125	210,142	697,451	1,809,718	1,809,718	(116,048)	1,693,670				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 Hillview Health Care Center

0045302

Report Period Beginning: Jan. 1, 2003

Ending: Dec. 31, 2003

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 Program				3
4	Non-Patient Meals	(564)	2		4
5	Telephone, TV & Radio in Resident Room				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patient				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refund				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(924)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transaction				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(25)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer				22
23	Malpractice Insurance for Individual				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotions				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employee				27
28	Yellow Page Advertising	(1,948)	20		28
29	Other-Attach Schedule	(6,276)	27		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (9,737)		\$	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)	(58,556)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (58,556)		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (68,293)		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			\$		38
39						39
40	Gift and Coffee Shop					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology	X		(3,505)	43	42
43	Prescription Drugs	X		(44,250)	10	43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ (47,755)		47

Hillview Health Care Center

ID# 0045302

Report Period Beginning: Jan. 1, 2003

Ending: Dec. 31, 2003

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	PRIOR PERIOD EXEPENE	\$ (6,276)	27	1
2	PHARMACY	(40,065)	10	2
3	LAB & XRAY	(3,505)	43	3
4	IV THERAPY	(4,185)	10	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
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27				27
28				28
29				29
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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	(54,031)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hillview Health Care Center

0045302

Report Period Beginning:

Jan. 1, 2003

Ending:

Dec. 31, 2003

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)	
	A. General Services													
1	Dietary	0	12	0	0	0	0	0	0	0	0	0	12	1
2	Food Purchase	(564)	0	0	0	0	0	0	0	0	0	0	(564)	2
3	Housekeeping	0	2,810	0	0	0	0	0	0	0	0	0	2,810	3
4	Laundry	0	17	0	0	0	0	0	0	0	0	0	17	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	203	0	0	0	0	0	0	0	0	0	203	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(564)	3,042	0	2,478	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	(44,250)	(6,415)	0	0	0	0	0	0	0	0	0	(50,665)	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	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	TOTAL Health Care and Programs	(44,250)	(6,415)	0	(50,665)	16								
	C. General Administration													
17	Administrative	0	(64,295)	0	0	0	0	0	0	0	0	0	(64,295)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(1,948)	0	0	0	0	0	0	0	0	0	0	(1,948)	20
21	Clerical & General Office Expenses	0	(29)	0	0	0	0	0	0	0	0	0	(29)	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):*	(7,225)	0	0	0	0	0	0	0	0	0	0	(7,225)	27
28	TOTAL General Administration	(9,173)	(64,324)	0	(73,497)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(53,987)	(67,697)	0	(121,684)	29								

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
Health Systems, Inc.	100%	See Schedule G Home Office	Various	N/A	N/A	Management Co
Med Supply	100%					Medical Supplies
Sterling Health	100%					General Supplies
Systems Leasing	100%					Leasing Company

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17 Management Fees	\$ 111,464	Health Systems, Inc.	100.00%	\$ 47,169	\$ (64,295)	1
2	V	34 Capital Cost		Health Systems, Inc.	100.00%	9,890	9,890	2
3	V	10 Nursing Supplies	39,149	Med Supply	100.00%	31,961	(7,188)	3
4	V	21 Employee Benefits	156	Med Supply	100.00%	127	(29)	4
5	V	39 Oxygen Supplies	30	Med Supply	100.00%	24	(6)	5
6	V	10 Nursing Supplies	2,470	Sterling Health	100.00%	3,247	777	6
7	V	1 Dietary	39	Sterling Health	100.00%	51	12	7
8	V	4 Laundry Supplies	53	Sterling Health	100.00%	70	17	8
9	V	3 Housekeeping Supplies	8,933	Sterling Health	100.00%	11,743	2,810	9
10	V	6 Plant Supplies	645	Sterling Health	100.00%	848	203	10
11	V	10 Nursing Supplies	27	Systems Leasing	100.00%	23	(4)	11
12	V	39 Oxygen Supplies	383	Systems Leasing	100.00%	320	(63)	12
13	V	35 Equipment Rental	4,127	Systems Leasing	100.00%	3,447	(680)	13
14	Total		\$ 167,476			\$ 108,920	\$ * (58,556)	14

* Total must agree with the amount recorded on line 34 of Schedule V1

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	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		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 Hillview Health Care Center # 0045302 Report Period Beginning: Jan. 1, 2003 Ending: c. 31, 2003

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3		SEE HOME OFFICE COST REPORT							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				\$	\$		\$	25

Facility Name & ID Number Hillview Health Care Center

0045302

Report Period Beginning:

Jan. 1, 2003

Ending:

Dec. 31, 2003

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									
						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	NONE						\$	\$		\$	1								
2											2								
3											3								
4											4								
5											5								
	Working Capital																		
6	NONE										6								
7											7								
8											8								
9	TOTAL Facility Related					\$	\$		\$		9								
	B. Non-Facility Related*																		
10	NONE										10								
11											11								
12											12								
13											13								
14	TOTAL Non-Facility Related					\$	\$		\$		14								
15	TOTALS (line 9+line14)					\$	\$		\$		15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ 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

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and l must accompany the cost report</p>			
1. Real Estate Tax accrual used on 2002 report.		\$ 20,107	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.)		\$ 21,526	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 1,419	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 21,526	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		\$ 22,945	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1998	16,513	8
	1999	16,182	9
	2000	16,325	10
	2001	27,516	11
	2002	20,107	12
	FOR OHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2002 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

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 filec

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 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 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 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 2003 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 Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Hillview Health Care Center COUNTY Johnson

FACILITY IDPH LICENSE NUMBER 0045302

CONTACT PERSON REGARDING THIS REPORT Buford L. Snipes

TELEPHONE 573-481-9858 FAX #: 573-481-9859

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 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 2002.

(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>08-05-201--008</u>	<u>S PT W PT N 1/2 SW NE QTR</u>	<u>\$ 21,525.00</u>	<u>\$ 21,525.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ 21,525.00	\$ 21,525.00

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 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Hillview Health Care Center

0045302 Report Period Beginning:

Jan. 1, 2003 Ending: Dec. 31, 2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 21,207 B. General Construction Type: Exterior Concrete Block Frame Wood Number of Stories 1 + Basement

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 ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, et List entity name, type of business, square footage, and number of beds/units available (where applicable)
NONE

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

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
Improvement Type**											
9	NONE										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

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	NONE		\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$	\$		\$	\$	\$	70

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

Facility Name & ID Number Hillview Health Care Centre

0045302

Report Period Beginning:

Jan. 1, 2003

Ending:

Dec. 31, 2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instruction

	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	\$ NONE	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$	\$	\$	\$		\$	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	NONE			\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Asset

	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)		\$ NONE	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$	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	NONE	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	NONE	\$	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 1

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Vienna RE, LLC
 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:	<u>UNKNOWN</u>	<u>71</u>	<u>4-13-2001</u>	\$	<u>20</u>	<u>10</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		<u>71</u>		\$			7

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.	<u>12/31/2004</u>	\$ <u>132,000</u>
13.	<u>12/31/2005</u>	\$ <u>132,000</u>
14.	<u>12/31/2006</u>	\$ <u>132,000</u>

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: \$ _____ Description: _____
 (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

* 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.

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>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 AIDE _____</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 AIDE _____</p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wage (c)				
6	Transportation				
7	Contractual Payment:				
8	Nurse Aide 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 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)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefit.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefit.
- (c) For in-house training programs only. Do not include fringe benefit.
- (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	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Total Cost (Col. 3 + 5 + 6)							
					Units	Cost								
1	Licensed Occupational Therapist		hrs	\$		\$	28,897	\$		\$	28,897		1	
2	Licensed Speech and Language Development Therapist		hrs				6,216				6,216		2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist		hrs				56,117				56,117		4	
5	Physician Care		visits										5	
6	Dental Care		visits										6	
7	Work Related Program		hrs										7	
8	Habilitation		hrs										8	
9	Pharmacy		# of prescripts				39,532				39,532		9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10	
11	Academic Education		hrs										11	
12	Exceptional Care Program												12	
13	Other (specify):												13	
14	TOTAL			\$		\$	130,762	\$		\$	130,762		14	

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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	\$ 24,433	\$	1
2	Cash-Patient Deposits	1,471		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	166,563		3
4	Supply Inventory (priced at <u>COST</u>)	5,558		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	291,379		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 489,404	\$	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			15
16	Equipment, at Historical Cost	6,727		16
17	Accumulated Depreciation (book methods)	(593)		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)	\$ 6,134	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 495,538	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 46,109	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,471		28
29	Short-Term Notes Payable	100,000		29
30	Accrued Salaries Payable	59,016		30
31	Accrued Taxes Payable (excluding real estate taxes)	37,394		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>INTERCOMPANY</u>	292,883		36
37	<u>LEASE PAYABLE</u>	11,000		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 547,873	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 547,873	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (52,335)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 495,538	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (318,255)	1
2	Restatements (describe):		2
3	Accrued Sick Leave	4,499	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (313,756)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	261,421	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 Owner:	()	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)	\$ 261,421	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)	\$ (52,335)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Hillview Health Care Center

0045302

Report Period Beginning: Jan. 1, 2003

Ending: Dec. 31, 2003

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 expenses.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,956,853	1
2	Discounts and Allowances for all Levels	(224,415)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,732,438	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	164,672	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 164,672	8
C. Other Operating Revenue			
9	Payments for Educator		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursement		11
12	Gift and Coffee Shop	488	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	564	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	61,097	17
18	Sale of Supplies to Non-Patient		18
19	Laboratory	2,969	19
20	Radiology and X-Ray	1,717	20
21	Other Medical Services	10,951	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 77,786	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income**	274	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 274	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	CABLE TV AND PRIOR PERIOD	45,234	28
28a	BAD DEBTS	50,735	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 95,969	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,071,139	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	409,783	31
32	Health Care	801,389	32
33	General Administrator	402,633	33
B. Capital Expense			
34	Ownership	162,182	34
C. Ancillary Expense			
35	Special Cost Centers	4,230	35
36	Provider Participation Fee	29,501	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,809,718	40
41	Income before Income Taxes (line 30 minus line 40)**	261,421	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 261,421	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 Hillview Health Care Center

0045302

Report Period Beginning: Jan. 1, 2003

Ending:

Dec. 31, 2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,920	2,080	\$ 37,274	\$ 17.92	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,088	5,343	77,906	14.58	3
4	Licensed Practical Nurses	9,492	9,860	115,877	11.75	4
5	Nurse Aides & Orderlies	38,257	40,218	304,760	7.58	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,787	2,008	18,827	9.38	9
10	Activity Assistants					10
11	Social Service Worker	1,678	1,948	17,586	9.03	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	12,498	13,904	112,539	8.09	15
16	Dishwashers					16
17	Maintenance Worker	1,668	1,922	27,890	14.51	17
18	Housekeepers	6,897	7,192	48,032	6.68	18
19	Laundry	3,571	3,871	27,856	7.20	19
20	Administrator	1,952	2,080	48,340	23.24	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,795	1,972	23,899	12.12	23
24	Clerical					24
25	Vocational Instructor					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	3,127	3,524	43,314	12.29	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	89,730	95,922	\$ 904,100 *	\$ 9.43	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	\$ 4,349	1-3	35
36	Medical Director	5,400	7-3	36
37	Medical Records Consultant	2,251	10-3	37
38	Nurse Consultant			38
39	Pharmacist Consultant	3,408	10-3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant	1,648	12-3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 17,056		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. 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		
Tammy Samuels	Administrator		48,340	Workers' Compensation Insurance	33,011	IDPH License Fee	1,500		
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	1,011		
				FICA Taxes	88,665	Health Care Worker Background Check	598		
				Employee Health Insurance	25,131	(Indicate # of checks performed 46)			
				Employee Meals		Advertising--Other	1,948		
				Illinois Municipal Retirement Fund (IMRF)*		Periodicals	557		
						Secretary of State	200		
						Miscellaneous	8		
TOTAL (agree to Schedule V, line 17, col. 1)			48,340						
(List each licensed administrator separately.)									
B. Administrative - Other									
Description			Amount						
Management Fees			101,281						
TOTAL (agree to Schedule V, line 17, col. 3)			101,281						
(Attach a copy of any management service agreement)									
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
CT Corporation	Legal		280	NONE			Out-of-State Travel		
TBT Enterprises	Profess. Fees		9,316						
Health Systems, Inc.	Cost Reports		5,100				In-State Travel	1,911	
Beussink, Hey & Roe	Accounting		880						
Health Services	Consulting		1,022				Seminar Expense		
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			Entertainment Expense		
(If total legal fees exceed \$2500 attach copy of invoices.)			16,598				(agree to Sch. V, line 24, col. 8)		
							TOTAL	1,911	

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union NO
- (2) Are there any dues to nursing home associations included on the cost report YES
If YES, give association name and amount _____
- (3) Did the nursing home make political contributions or payments to a political 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? 5 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expenses and the location of this expense on Sch. V. N/A Line _____
- (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? _____
If YES, give effective date of lease NO
- (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. ?
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 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 if 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. \$ 0 Has any meal income been offset against related costs? _____ 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? _____ If YES, please indicate the amount of income earned from such program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? _____
d. Have vehicle usage logs been maintained? _____
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? _____
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
g. Does the facility transport residents to and from day training? 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? N/A
Attach invoices and a summary of services for all architect and appraisal fees _____