

Facility Name & ID Number HILLCREST HEALTHCARE CENTER

0037572 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

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	84	Skilled (SNF)	84	30,744	1
2		Skilled Pediatric (SNF/PED)			2
3	84	Intermediate (ICF)	84	30,744	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	168	TOTALS	168	61,488	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			3,187	3,187	8
9	SNF/PED					9
10	ICF	47,659	1,102		48,761	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,659	1,102	3,187	51,948	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.48%

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 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 number of beds certified 18 and days of care provided 3,187

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

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

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	175,645	23,208	14,324	213,177		213,177	(1,092)	212,085		1
2	Food Purchase		202,702		202,702	(13,286)	189,416	(343)	189,073		2
3	Housekeeping	193,792	25,293		219,085		219,085		219,085		3
4	Laundry	43,639	14,010		57,649		57,649		57,649		4
5	Heat and Other Utilities			121,434	121,434		121,434	720	122,154		5
6	Maintenance	53,422	40,748	54,072	148,242		148,242	10,852	159,094		6
7	Other (specify):*			15,761	15,761		15,761	378	16,139		7
8	TOTAL General Services	466,498	305,961	205,591	978,050	(13,286)	964,764	10,515	975,279		8
	B. Health Care and Programs										
9	Medical Director			23,600	23,600		23,600		23,600		9
10	Nursing and Medical Records	1,279,206	52,662	145,894	1,477,762		1,477,762	(97,327)	1,380,435		10
10a	Therapy	71,403	2,527	38,606	112,536		112,536	(30,355)	82,181		10a
11	Activities	90,151	22,639		112,790		112,790		112,790		11
12	Social Services	286,092			286,092		286,092		286,092		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,726,852	77,828	208,100	2,012,780		2,012,780	(127,682)	1,885,098		16
	C. General Administration										
17	Administrative	104,091		220,000	324,091		324,091	(105,810)	218,281		17
18	Directors Fees										18
19	Professional Services			371,186	371,186		371,186	(202,100)	169,086		19
20	Dues, Fees, Subscriptions & Promotions			24,918	24,918		24,918	(14,278)	10,640		20
21	Clerical & General Office Expenses	144,180	15,884	156,601	316,665		316,665	(5,812)	310,853		21
22	Employee Benefits & Payroll Taxes			394,680	394,680	13,286	407,966		407,966		22
23	Inservice Training & Education			2,127	2,127		2,127	1,331	3,458		23
24	Travel and Seminar							438	438		24
25	Other Admin. Staff Transportation			2,928	2,928		2,928	4,421	7,349		25
26	Insurance-Prop.Liab.Malpractice			129,200	129,200		129,200	2,782	131,982		26
27	Other (specify):*							49,044	49,044		27
28	TOTAL General Administration	248,271	15,884	1,301,640	1,565,795	13,286	1,579,081	(269,984)	1,309,097		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,441,621	399,673	1,715,331	4,556,625		4,556,625	(387,151)	4,169,474		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	DIETARY		
	DIETITIAN CONSULTANT	XVIII B 35-2	9,405
	REPAIRS & MAINTENANCE		4,919
			0
			14,324
3	HOUSEKEEPING		
			0
			0
			0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		0
			0
			0
5	HEAT & OTHER UTILITIES		
	GAS HEAT		17,417
	ELECTRICITY		66,361
	WATER		36,952
	CABLE TV - LOBBY		704
			0
			121,434
6	MAINTENANCE		
	GROUNDS MAINTENANCE		8,934
	PAINTING & DECORATING		0
	BUILDING REPAIRS		5,539
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		13,779
	ELEVATOR MAINTENANCE & REPAIR		14,742
	OUTSIDE LABOR		0
	EXTERMINATING SERVICE		3,609
	FIRE SERVICE		7,469
			0
			0
			0
			54,072
7	OTHER		
	SCAVENGER		15,761
	SECURITY SERVICE		0
			15,761
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	23,600
			23,600

LINE		SCHED REF	TOTAL
10	NURSING		
	CONTRACT NURSING	XVIII C 53-2	0
	LABORATORY & XRAY EXPENSE		154
	PURCHASED SERVICES		272
	PSYCHO-SOCIAL CONSULTANT	XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	4,946
	PHARMACY CONSULTANT	XVIII B 39-2	672
	UTILIZATION REVIEW FEES	XVIII B ___-2	0
	PHYSICIANS	XVIII B 48-2	0
	PSYCHIATRIC	XVIII B 47-2	110,500
	RN CONSULTANT	XVIII B 38-2	0
	PUBLIC AID CONSULTANTS		25,000
	DENTAL SERVICES		4,350
			145,894
10a	THERAPY		
	PHYSICAL THERAPY SERVICES		0
	SPEECH THERAPY SERVICES		297
	OCCUPATIONAL THERAPY SERVICES		972
	THERAPY CONTRACT SERVICES		26,537
	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
			38,606
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS		0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0
			0
			0
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0
	SOCIAL WORKER	XVIII B 45-2	0
			0
			0
13	NURSE AIDE TRAINING		
	NURSE AIDE TRAINING COSTS	XIII	0
			0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	220,000
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	25,253
	ADMINISTRATIVE CONSULTANTS XIX C	193,000
	PROFESSIONAL FEES XIX C	152,933
		0
		371,186
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	15,864
	EMPLOYEE WANT ADS XIX F	6,521
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	438
	LICENSES & PERMITS XIX F	433
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	1,412
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	200
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	50
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
		24,918
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,675
	EQUIPMENT REPAIR & MAINTENANCE	7,637
	OUTSIDE CLERICAL SERVICES	100,800
	PENALTIES / OVERDRAFT CHARGES VI 18	16,242
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	29,241
	MESSENGER SERVICE	1,006
		0
		156,601

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	183,575
	UNEMPLOYMENT COMPENSATION XIX D	25,394
	WORKERS COMPENSATION INSURANCI XIX D	50,197
	HOSPITALIZATION INSURANCE XIX D	110,426
	EMPLOYEE BENEFITS - OTHER XIX D	25,088
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		394,680
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	2,127
		2,127
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
		0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	2,928
		2,928
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	129,200
		129,200
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

1,715,331

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			38,395	38,395		38,395	11,674	50,069		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			47,642	47,642		47,642	30,624	78,266		32
33	Real Estate Taxes			71,068	71,068		71,068		71,068		33
34	Rent-Facility & Grounds			621,972	621,972		621,972	6,548	628,520		34
35	Rent-Equipment & Vehicles			63,192	63,192		63,192	(21,117)	42,075		35
36	Other (specify):*										36
37	TOTAL Ownership			842,269	842,269		842,269	27,729	869,998		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		142,148	34,318	176,466		176,466	(28,703)	147,763		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			92,232	92,232		92,232		92,232		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		142,148	126,550	268,698		268,698	(28,703)	239,995		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,441,621	541,821	2,684,150	5,667,592		5,667,592	(388,125)	5,279,467		45

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

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,000	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	(343)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(200)	20		17
18	Fines and Penalties	(16,242)	21		18
19	Entertainment				19
20	Contributions	(50)	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	(15,864)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,412)	20		28
29	Other-Attach Schedule	3,521			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (29,590)		\$	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)	(358,535)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (358,535)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (388,125)		37

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

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

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

ID# 0037572

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	DEFERRED MAINTENANCE	\$ 3521	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			48
49	Total	3,521	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number HILLCREST HEALTHCARE CENTER# 0037572

Report Period Beginning:

01/01/2004

Ending:

12/31/2004**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	(1,092)	0	0	0	0	0	0	0	0	0	(1,092)	1
2	Food Purchase	(343)	0	0	0	0	0	0	0	0	0	0	(343)	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	720	0	0	0	0	0	0	0	0	0	720	5
6	Maintenance	3,521	7,331	0	0	0	0	0	0	0	0	0	10,852	6
7	Other (specify):*	0	0	378	0	0	0	0	0	0	0	0	378	7
8	TOTAL General Services	3,178	6,959	378	0	10,515	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(97,327)	0	0	0	0	0	0	0	0	0	(97,327)	10
10a	Therapy	0	3,655	(34,010)	0	0	0	0	0	0	0	0	(30,355)	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	0	(93,672)	(34,010)	0	(127,682)	16							
	C. General Administration													
17	Administrative	0	(105,810)	0	0	0	0	0	0	0	0	0	(105,810)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(206,200)	4,100	0	0	0	0	0	0	0	0	(202,100)	19
20	Fees, Subscriptions & Promotions	(17,526)	0	3,248	0	0	0	0	0	0	0	0	(14,278)	20
21	Clerical & General Office Expenses	(16,242)	(100,800)	111,230	0	0	0	0	0	0	0	0	(5,812)	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	1,331	0	0	0	0	0	0	0	0	1,331	23
24	Travel and Seminar	0	0	438	0	0	0	0	0	0	0	0	438	24
25	Other Admin. Staff Transportation	0	0	4,421	0	0	0	0	0	0	0	0	4,421	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,782	0	0	0	0	0	0	0	0	2,782	26
27	Other (specify):*	0	0	49,044	0	0	0	0	0	0	0	0	49,044	27
28	TOTAL General Administration	(33,768)	(412,810)	176,594	0	(269,984)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(30,590)	(499,523)	142,962	0	(387,151)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number HILLCREST HEALTHCARE CENTER# 0037572

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

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)	
	D. Ownership													
30	Depreciation	1,000	0	10,674	0	0	0	0	0	0	0	0	11,674	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	30,624	0	0	0	0	0	0	0	0	30,624	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	6,548	0	0	0	0	0	0	0	0	6,548	34
35	Rent-Equipment & Vehicles	0	0	(21,117)	0	0	0	0	0	0	0	0	(21,117)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	1,000	0	26,729	0	27,729	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	(28,703)	0	0	0	0	0	0	0	0	(28,703)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	(28,703)	0	(28,703)	44							
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(29,590)	(499,523)	140,988	0	(388,125)	45							

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				CAREPLUS MGMT	SKOKIE	MGMT/CLERICAL
				CAREPLUS REHABILITATIVE SERVICES		
SEE ATTACHED SCHEDULES					SKOKIE	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	193,000	" "			(193,000)	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	4,200	" "			(4,200)	5
6	V	10	PA,PSYCH CONSULT FEES	125,000	" "			(125,000)	6
7	V	1	DIETARY SALARIES		" "			3,108	7
8	V	5	ELECTRICITY		" "			720	8
9	V	6	REPAIRS		" "			25	9
10	V	6	MAINTENANCE SALARIES		" "			7,306	10
11	V	10	NURSING		" "			27,673	11
12	V	10a	THERAPY SALARIES		" "			3,655	12
13	V	17	ADMIN SALARIES		" "			74,190	13
14	Total		\$ 616,200				\$	116,677	\$ * (499,523) 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	19 PROFESSIONAL FEES	\$	CAREPLUS MGMT INC		\$ 4,100	\$ 4,100
16	V	20 DUES/LICENSES/WANT ADS		" "		3,248	3,248
17	V	21 OFFICE SALARIES/EXPENSES		" "		111,230	111,230
18	V	23 SEMINARS		" "		1,331	1,331
19	V	24 TRAVEL		" "		438	438
20	V	25 TRANSPORTATION		" "		4,421	4,421
21	V	26 INSURANCE		" "		2,782	2,782
22	V	27 EMPLOYEE BENEFITS		" "		49,044	49,044
23	V	30 SL DEPRECIATION		" "		10,674	10,674
24	V	32 INTEREST		" "		30,624	30,624
25	V	34 OFFICE RENT		" "		6,548	6,548
26	V	35 EQUIP RENT/AUTO LEASE		" "		7,104	7,104
27	V	7 SECURITY		" "		378	378
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V	10a THERAPY SERVICES	38,606	CAREPLUS REHABILITATIVE SERVICES		4,596	(34,010)
35	V	39 ANCILLARY THERAPY	34,317	" "		5,614	(28,703)
36	V	35 EQUIPMENT RENT EXPENSE	28,221	" "			(28,221)
37	V			" "			
38	V			" "			
39	Total		\$ 101,144			\$ 242,132	\$ * 140,988

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

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

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	2	3	4	5	6		7		8	9	
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**				
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference		
1	CAREPLUS MGMT ALLOCATIONS:							\$		1	
2	SHERWIN RAY	PRESIDENT	ADMIN/FINANCE	34.67	SEE ATTACHED	5.5	9.18	SALARY	16,992	17-7	2
3	JAKOB BAKST	DIR OPERAT'NS	ADMIN/CONS.	34.67	SCHEDULES	5.5	9.18	" "	16,992	17-7	3
4	JOE ZIMMERMAN	CFO	CLERICAL	0.60	" "	5.5	9.18	" "	12,170	21-7	4
5	JANICE CLAFFORD	CONTROLLER	CLERICAL	0.60	" "	5.5	9.18	" "	5,826	21-7	5
6	ROMY MACASAET	RN CONSULT.	NURSING	0.60	" "	5.5	9.18	" "	7,692	10-7	6
7	JAMEE O'BRIEN	REGIONAL DIR.	ADMIN	0.60	" "	5.5	9.18	" "	12,161	17-7	7
8	ROSLYN INDICH	BKKP	CLERICAL	2.38	" "	5.5	9.18	" "	5,355	21-7	8
9											9
10	HUNTER MGMT LLC -- ERIC ROTHNER		MGMT	21.13	" "			MGMT FEES	40,000	17-3	10
11											11
12											12
13								TOTAL	\$ 117,188		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: 01/01/2004

Ending: 2/31/2004

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	451,049	9 FACILITIES	\$ 26,990	\$ 26,990	51,948	\$ 3,108	1
2	5	ELECTRICITY	565,586	13 FACILITIES	7,834		51,948	720	2
3	6	REPAIRS	565,586	13 FACILITIES	275		51,948	25	3
4	6	MAINTENANCE SALARIES	565,586	13 FACILITIES	79,548	79,548	51,948	7,306	4
5	10	NURSING	565,586	13 FACILITIES	301,295	301,295	51,948	27,673	5
6	10a	THERAPY SALARIES	565,586	13 FACILITIES	39,798	39,798	51,948	3,655	6
7	17	ADMIN SALARIES	565,586	13 FACILITIES	807,745	807,745	51,948	74,190	7
8	19	PROFESSIONAL FEES	565,586	13 FACILITIES	44,637		51,948	4,100	8
9	20	DUES/LICENSES/WANT ADS	565,586	13 FACILITIES	35,362		51,948	3,248	9
10	21	OFFICE SALARIES/EXPENSES	565,586	13 FACILITIES	1,211,025	819,289	51,948	111,230	10
11	23	SEMINARS	565,586	13 FACILITIES	14,490		51,948	1,331	11
12	24	TRAVEL	565,586	13 FACILITIES	4,769		51,948	438	12
13	25	TRANSPORTATION	565,586	13 FACILITIES	48,136		51,948	4,421	13
14	26	INSURANCE	565,586	13 FACILITIES	30,286		51,948	2,782	14
15	27	EMPLOYEE BENEFITS	565,586	13 FACILITIES	533,964		51,948	49,044	15
16	30	SL DEPRECIATION	565,586	13 FACILITIES	116,219		51,948	10,674	16
17	32	INTEREST	565,586	13 FACILITIES	333,416		51,948	30,624	17
18	34	OFFICE RENT	565,586	13 FACILITIES	71,288		51,948	6,548	18
19	35	EQUIP RENT/AUTO LEASE	565,586	13 FACILITIES	77,344		51,948	7,104	19
20	7	SECURITY	565,586	13 FACILITIES	4,112		51,948	378	20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,788,533	\$ 2,074,665		\$ 348,599	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2	3	4	5	6	7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	CAREPLUS MANAGEMENT ALLOCATION: LOC, ETC									\$ 30,624	1	
2											2	
3											3	
4	CAREPLUS MGMT - CIB BK	X		CAPL IMPR LOAN FEES	5 YR AMORT	2/23/01	2,250		W/O BAL		975	4
5	CAREPLUS MGMT - CIB BK	X		CAPITAL IMPROVEMENT	\$5,065.78	1/04	213,229	169,214	1/09	PRIME+	24,019	5
	Working Capital											
6	CAREPLUS MGMT - CIB BK	X		WORKING CAPITAL	DEMAND	04/95	1,925,000	757,836		PRIME+	22,383	6
7	INSURANCE FINANCING		X	INSUR. FINANCE							265	7
8												8
9	TOTAL Facility Related				\$5,065.78		\$ 2,140,479	\$ 927,050			\$ 78,266	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 2,140,479	\$ 927,050			\$ 78,266	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.

\$ **72,300** 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.)

\$ **71,328** 2

3. Under or (over) accrual (line 2 minus line 1).

\$ **(972)** 3

4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)

\$ **72,040** 4

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C.
(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)

\$ 5

6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.

TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)

\$ 6

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

\$ **71,068** 7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1999	61,241	8
	2000	64,403	9
	2001	66,911	10
	2002	71,585	11
	2003	71,328	12

FOR OHF USE ONLY

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

13 FROM R. E. TAX STATEMENT FOR 2003 \$ 13

14 PLUS APPEAL COST FROM LINE 5 \$ 14

15 LESS REFUND FROM LINE 6 \$ 15

THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.

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 filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 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 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 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 2004 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.

2003 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 Cost

Enter the tax index number and real estate tax assessed for 2003 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 2003.

(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>30-07-11-101-003-0000</u>	<u>NURSING HOME</u>	\$ <u>71,327.86</u>	\$ <u>71,327.86</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>71,327.86</u>	\$ <u>71,327.86</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number HILLCREST HEALTHCARE CENTER

0037572

Report Period Beginning:

01/01/2004 Ending:

12/31/2004

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).

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

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

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

XI. OWNERSHIP COSTS:

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

Facility Name & ID Number **HILLCREST HEALTHCARE CENTER**# **0037572**

Report Period Beginning:

01/01/2004 Ending: 12/31/2004

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		LEASEHOLD IMPROVEMENTS		1991	6,230	198	31.5	198		2,608	9
10		LEASEHOLD IMPROVEMENTS		1992	48,072	1,525	31.5	1,526	1	19,075	10
11		LEASEHOLD IMPROVEMENTS		1993	33,291	981	31.5	1,057	76	12,155	11
12		LEASEHOLD IMPROVEMENTS		1994	10,172	261	39	261		2,708	12
13		ROOF REPAIR		1995	5,221	134	39	134		1,245	13
14		CONDENSING UNITS		1996	3,924	101	39	101		871	14
15		CEILING TILES		1996	1,334	34	39	34		288	15
16		ROOF REPAIR		1996	8,079	207	39	207		1,734	16
17		DOORS		1997	1,078	28	39	28		211	17
18		WINDOWS & ROOF VENTILATOR		1997	3,572	92	39	92		648	18
19		WINDOWS		1998	12,100	309	39	310	1	2,047	19
20		ROOF REPAIRS/DOORS/ELEC. REPAIRS/LOT LIGHTS		1998	23,693	607	39	607		3,982	20
21		WALLCOVER/RAILS/NURSE STNS/WINDOW TREATMENTS		1998	155,436	3,985	39	3,985		25,807	21
22		WINDOWS/DECORATING/CEILING TILE/ROOF REPAIR		1999	70,751	1,814	39	1,814		10,022	22
23		WINDOWS/FLOORING/DOOR		2000	12,169	442	27.5	442		2,050	23
24		CARPETING		2000	2,088	186	10	209	23	940	24
25		DOORS/ELEVATOR REPAIRS/SECURITY SYSTEM UPGRADE		2001	42,268	1,536	27.5	1,537	1	5,716	25
26		FENCE		2001	10,361	691	15	691		2,418	26
27		ROOF REPAIRS/CEILING TILE/FIRE DAMPERS/LIGHTING		2001	43,148	1,568	27.5	1,569	1	5,010	27
28		ROOF REPAIRS/HEAT/AC REPAIRS		2002	12,346	450	27.5	449	(1)	1,081	28
29		FENCE		2002	4,573	305	15	305		762	29
30		DOOR REPLACEMENTS/DUCTWORK-FIRE CODE		2003	7,297	266	27.5	265	(1)	444	30
31		WALL A/C UNIT INSTALLATIONS / ELEVATOR BUTTONS		2003	66,500	3,355	27.5	3,355		4,241	31
32		DURO-LAST ROOF SYSTEM		2003	92,265	2,418	27.5	2,418		3,325	32
33		FENCE / PARKING LOT SEAL		2003	8,816	588	15	588		882	33
34											34
35		RELATED PARTY ALLOCATION - CAREPLUS MGMT				108		108			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	TOTAL (lines 4 thru 69)		\$ 684,784	\$ 22,189		\$ 22,290	\$ 101	\$ 110,270	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 202,427	\$ 16,314	\$ 17,213	\$ 899	8-15 YRS	\$ 103,748	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	** RELATED PARTY - SL DEPN: CAREPLUS MGMT, 10566		10,566	10,566				74
75	TOTALS	\$ 202,427	\$ 26,880	\$ 27,779	\$ 899		\$ 103,748	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 887,211	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 49,069	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 50,069	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,000	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 214,018	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 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>168</u>	<u>9/15/91</u>	\$ <u>621,972</u>	<u>15</u>		3
4	Additions						4
5							5
6							6
7	TOTAL	<u>168</u>		\$ <u>621,972</u>			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 55,678 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>	<u>FACILITY FORD VAN</u>	\$ <u>683.10</u>	\$ <u>7,514</u>	17
18	<u>MAINT</u>				18
19					19
20					20
21	TOTAL		\$ <u>683.10</u>	\$ <u>7,514</u>	21

10. Effective dates of current rental agreement:

Beginning 9/15/91

Ending 9/15/06

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

Fiscal Year Ending Annual Rent

12. /2005 \$ _____

13. /2006 \$ _____

14. /2007 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO 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. <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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	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 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	\$		\$ 33,211	\$		\$ 33,211	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			675			675	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			432			432	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				132,234		132,234	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	MED.SUPPLIES/LAB/RENTALS Other (specify):	39-2					9,914		9,914	13
14	TOTAL			\$		\$ 34,318	\$ 142,148		\$ 176,466	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

0037572

Report Period Beginning: 01/01/2004

Ending:

12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2004

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>38,288</u>)	1,797,404		3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	91,464		6
7	Other Prepaid Expenses	9,180		7
8	Accounts Receivable (owners or related parties)	25,000		8
9	Other(specify): <u>R.E,TAX ESCROW</u>	47,336		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,970,384	\$	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	729,764		15
16	Equipment, at Historical Cost	211,109		16
17	Accumulated Depreciation (book methods)	(294,726)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): _____			22
23	Other(specify): <u>SECURITY DEP</u>	1,366		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 647,513	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,617,897	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 952,818	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	757,836		29
30	Accrued Salaries Payable	123,560		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,513		31
32	Accrued Real Estate Taxes(Sch.IX-B)	72,040		32
33	Accrued Interest Payable	2,238		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	_____			36
37	_____			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,920,005	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	169,214		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)	\$ 169,214	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,089,219	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 528,678	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,617,897	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 531,331	1
2	Restatements (describe):		2
3	POST-CLOSING BAD DEBT ADJUSTMENT	(200,000)	3
4	POST-CLOSING EXPENSES	(60,125)	4
5	ROUNDING	1	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 271,207	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	257,471	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 257,471	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)	\$ 528,678	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached. Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,924,876	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,924,876	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	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	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	187	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 187	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,925,063	30

2

Expenses		Amount	
A. Operating Expenses			
31	General Services	978,050	31
32	Health Care	2,012,780	32
33	General Administration	1,565,795	33
B. Capital Expense			
34	Ownership	842,269	34
C. Ancillary Expense			
35	Special Cost Centers	176,466	35
36	Provider Participation Fee	92,232	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,667,592	40
41	Income before Income Taxes (line 30 minus line 40)**	257,471	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 257,471	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

TAX RETURN PREPARED ON CASH BASIS

*** 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: 01/01/2004

Ending: 12/31/2004

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	2,191	2,236	\$ 63,229	\$ 28.28	1
2	Assistant Director of Nursing	1,903	1,985	52,870	26.63	2
3	Registered Nurses	12,473	13,341	310,574	23.28	3
4	Licensed Practical Nurses	20,430	21,779	454,972	20.89	4
5	Nurse Aides & Orderlies	37,965	42,462	372,815	8.78	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,815	6,839	71,403	10.44	8
9	Activity Director	2,035	2,124	39,813	18.74	9
10	Activity Assistants	6,139	6,896	50,338	7.30	10
11	Social Service Workers	16,238	17,363	286,092	16.48	11
12	Dietician					12
13	Food Service Supervisor	1,997	2,184	28,803	13.19	13
14	Head Cook	5,614	6,223	51,651	8.30	14
15	Cook Helpers/Assistants	13,184	14,489	95,191	6.57	15
16	Dishwashers					16
17	Maintenance Workers	4,871	5,328	53,422	10.03	17
18	Housekeepers	26,013	28,230	193,792	6.86	18
19	Laundry	5,062	5,772	43,639	7.56	19
20	Administrator	2,495	2,719	68,460	25.18	20
21	Assistant Administrator	2,105	2,274	35,631	15.67	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,132	8,856	144,180	16.28	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	2,076	2,250	24,746	11.00	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	176,738	193,350	\$ 2,441,621 *	\$ 12.63	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 9,405	1-3	35
36	Medical Director	O	23,600	9-3	36
37	Medical Records Consultant	N	4,946	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	672	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	0	12-3	45
46	Other(specify)	S			46
47	PSYCHIATRIC		110,500	10-3	47
48	PA CONSULTANT		25,000	10-3	48
49	TOTAL (lines 35 - 48)		\$ 184,923		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 0	50
51	Licensed Practical Nurses		0	51
52	Nurse Aides		0	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	
ELLEN TIERNEY	ADMIN	0	\$ 57,822	Workers' Compensation Insurance	\$ 50,197	IDPH License Fee	\$	
JEFFREY BAKER	ADMIN	0	10,638	Unemployment Compensation Insurance	25,394	Advertising: Employee Recruitment	6,521	
JEFFREY BAKER	ASST ADMIN	0	33,301	FICA Taxes	183,575	Health Care Worker Background Check	0	
AMY WALKO	ASST ADMIN	0	2,330	Employee Health Insurance	110,426	(Indicate # of checks performed _____)		
				Employee Meals	13,286	MARKETING/ADV/PROMO	17,276	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	250	
				EMPLOYEE BENEFITS - OTHER	25,088	LICENSES & PERMITS	433	
				EMPLOYEE PHYSICAL EXAMS	0	DUES & SUBSCRIPTIONS	438	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOCATION	3,248	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(250)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(15,864)	
						Yellow page advertising	(1,412)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 104,091	TOTAL (agree to Schedule V, line 22, col.8)	\$ 407,966	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 10,640	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
CAREPLUS MGMT	MANAGEMENT FEES		\$ 180,000			\$	Out-of-State Travel	\$
HUNTER MANAGEMENT	MANAGEMENT FEES		40,000					
							In-State Travel	
							TRAVEL & LODGING	0
							MGMT CO ALLOCATION	438
							Seminar Expense	
								0
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 220,000	TOTAL		\$	TOTAL	\$ 438
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$					
SEE SCHEDULE ATTACHED			371,186					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 371,186					

* Attach copy of IMRF notifications

**See instructions.

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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13													
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
																	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	PAINT/DECORATING	2001	\$ 7,075	3	\$ 1,180	\$ 2,358	\$ 2,358	\$ 1,179	\$	\$	\$	\$	\$												
2	PAINT/DECORATING	2002	7,025	3		1,171	2,342	2,342	1,170																
3				3																					
4																									
5																									
6																									
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19																									
20	TOTALS		\$ 14,100		\$ 1,180	\$ 3,529	\$ 4,700	\$ 3,521	\$ 1,170	\$	\$	\$	\$												

Facility Name & ID Number HILLCREST HEALTHCARE CENTER# 0037572Report Period Beginning: 01/01/2004Ending: 12/31/2004**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? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (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. \$ 1,452 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. \$ 92,232
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. \$ 13,286 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees