

		FOR OHF USE					

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**2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)**

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>0037572</u></p> <p>Facility Name: <u>HILLCREST HEALTHCARE CENTER</u></p> <p>Address: <u>777 DRAPER AVE</u> <u>JOLIET</u> <u>60432</u> <small>Number City Zip Code</small></p> <p>County: <u>WILL</u></p> <p>Telephone Number: <u>(847) 329-1555</u> Fax # <u>(847) 329-9555</u></p> <p>IDPA ID Number: <u>36-3782789</u></p> <p>Date of Initial License for Current Owners: <u>09/15/91</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" 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 checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input 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>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<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>01/01/2005</u> to <u>12/31/2005</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 rowspan="3" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>SHERWIN I. RAY</u></td> </tr> <tr> <td>(Title) <u>MANAGER</u></td> </tr> <tr> <td rowspan="5">Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u></td> </tr> <tr> <td>(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> </tr> <tr> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>SHERWIN I. RAY</u>	(Title) <u>MANAGER</u>	Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>	(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>
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Facility Name & ID Number HILLCREST HEALTHCARE CENTER

0037572 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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	30,660	1
2		Skilled Pediatric (SNF/PED)			2
3	84	Intermediate (ICF)	84	30,660	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	168	TOTALS	168	61,320	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			2,440	2,440	8
9	SNF/PED					9
10	ICF	48,170	918		49,088	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	48,170	918	2,440	51,528	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.03%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 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 2,440

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

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

Facility Name & ID Number **HILLCREST HEALTHCARE CENTER** # **0037572** Report Period Beginning: **01/01/2005** Ending: **12/31/2005**

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	177,464	27,032	14,514	219,010		219,010		219,010		1
2	Food Purchase		198,166		198,166	(13,140)	185,026	(206)	184,820		2
3	Housekeeping	126,914	28,850		155,764		155,764		155,764		3
4	Laundry	68,600	14,680		83,280		83,280		83,280		4
5	Heat and Other Utilities			133,625	133,625		133,625	53	133,678		5
6	Maintenance	42,928	30,971	62,417	136,316		136,316	8,068	144,384		6
7	Other (specify):* SECURITY	54,865		14,347	69,212		69,212	41	69,253		7
8	TOTAL General Services	470,771	299,699	224,903	995,373	(13,140)	982,233	7,956	990,189		8
	B. Health Care and Programs										
9	Medical Director			20,300	20,300		20,300		20,300		9
10	Nursing and Medical Records	1,336,588	55,860	137,812	1,530,260		1,530,260	(92,600)	1,437,660		10
10a	Therapy	63,838	569	44,079	108,486		108,486	563	109,049		10a
11	Activities	100,713	30,543		131,256		131,256		131,256		11
12	Social Services	279,082			279,082		279,082		279,082		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,780,221	86,972	202,191	2,069,384		2,069,384	(92,037)	1,977,347		16
	C. General Administration										
17	Administrative	90,100		235,000	325,100		325,100	(78,435)	246,665		17
18	Directors Fees										18
19	Professional Services			268,850	268,850		268,850	(200,800)	68,050		19
20	Dues, Fees, Subscriptions & Promotions			19,669	19,669		19,669	(664)	19,005		20
21	Clerical & General Office Expenses	169,781	15,167	295,048	479,996		479,996	(164,519)	315,477		21
22	Employee Benefits & Payroll Taxes			355,718	355,718	13,140	368,858		368,858		22
23	Inservice Training & Education			2,075	2,075		2,075	1,401	3,476		23
24	Travel and Seminar							272	272		24
25	Other Admin. Staff Transportation			2,199	2,199		2,199	3,108	5,307		25
26	Insurance-Prop.Liab.Malpractice			40,064	40,064		40,064	1,577	41,641		26
27	Other (specify):*							61,025	61,025		27
28	TOTAL General Administration	259,881	15,167	1,218,623	1,493,671	13,140	1,506,811	(377,035)	1,129,776		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,510,873	401,838	1,645,717	4,558,428		4,558,428	(461,116)	4,097,312		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	9,098
	REPAIRS & MAINTENANCE	5,416
		0
		14,514
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	22,718
	ELECTRICITY	67,091
	WATER	33,097
	CABLE TV - LOBBY	10,719
		0
		133,625
6	MAINTENANCE	
	GROUNDS MAINTENANCE	5,035
	PAINTING & DECORATING	0
	BUILDING REPAIRS	1,160
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	25,841
	ELEVATOR MAINTENANCE & REPAIR	6,688
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	4,110
	FIRE SERVICE	19,583
		0
		0
		0
		62,417
7	OTHER	
	SCAVENGER	14,327
	SECURITY SERVICE	20
		14,347
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	20,300
		20,300

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	311
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	4,899
	PHARMACY CONSULTANT XVIII B 39-2	2,352
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B 47-2	100,000
	RN CONSULTANT XVIII B 38-2	0
	DENTAL SERVICES	5,250
	MEDICARE & PUBLIC AID CONSULTAN' XVIII B 48-2	25,000
		137,812
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	1,067
	SPEECH THERAPY SERVICES	432
	OCCUPATIONAL THERAPY SERVICES	405
	THERAPY CONTRACT SERVICES	31,375
	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
		44,079
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	235,000
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	26,925
	ADMINISTRATIVE CONSULTANTS XIX C	193,000
	PROFESSIONAL FEES XIX C	48,925
		0
		268,850
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	1,178
	EMPLOYEE WANT ADS XIX F	12,284
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	210
	LICENSES & PERMITS XIX F	2,495
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	2,802
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	200
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	500
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
		19,669
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,848
	EQUIPMENT REPAIR & MAINTENANCE	7,846
	OUTSIDE CLERICAL SERVICES	100,800
	PENALTIES / OVERDRAFT CHARGES VI 18	51,496
	HOME OFFICE EXPENSE	97,299
	THEFT & DAMAGE LOSS	71
	TELEPHONE	35,688
	MESSENGER SERVICE	0
		0
		295,048

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	187,990
	UNEMPLOYMENT COMPENSATION XIX D	30,563
	WORKERS COMPENSATION INSURANCE XIX D	49,014
	HOSPITALIZATION INSURANCE XIX D	54,351
	EMPLOYEE BENEFITS - OTHER XIX D	33,800
	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
		355,718
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	2,075
		2,075
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
		0
		0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	2,199
		2,199
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	39,564
	GENERAL INSURANCE EXPENSE	500
		40,064
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

1,645,717

HILLCREST HEALTHCARE CENTER
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2005

TOTAL FOOD PURCHASE	198,166	PATIENT MEALS	154584
LESS SALES TAX	(206)	ADD EMPLOYEE MEALS	10950
-----		-----	
NET FOOD	197,960	TOTAL MEALS/YEAR	165534
TOTAL PATIENT CENSUS	51,528	NET FOOD	197960
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	165534
-----		-----	
TOTAL PATIENT MEALS	154584	COST PER MEAL	1.2
 		TIME EMPLOYEE MEALS	10950
ADD # EMPLOYEE MEALS/DAY	30	-----	
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	13140
-----		=====	
TOTAL EMPLOYEE MEALS	10950		

HILLCREST HEALTHCARE CENTER, INC EQUIPMENT RENTAL 12/31/05		
RCS MANAGEMENT	NURSING EQUIPMENT	1,214
KREG THERAPEUTICS	NURSING EQUIPMENT	256
FAMILY PRIDE	WASHER & DRYER	9,000
JOHNSON WATER CONDITIONER	PLANT EQUIPMENT	420
MEIKEM SUPPLY INC	DISHWASHER	40
AIR CLEANING SPECIALISTS	AIR PURIFIERS	1,881
GE CAPITAL	COPIER	1,213
CITICORP VENDOR FINANCE	COPIER	2,338
TOSHIBA AMERICA	COPIER	2,172
CAREPLUS REHAB	EQUIPMENT/FURNITURE/COMPUTERS	34,735

		53,267

HILLCREST HEALTHCARE CENTER INC STAFF TRANSPORTATION 12/31/05				
ACCT #18370				
	AMY WALKO	JEFF BAKER	SEC OF STATE	TOTAL

JAN				0.00
FEB		212.91		212.91
MAR		136.99	78.00	214.99
APR		241.52		241.52
MAY		121.96		121.96
JUN		493.70		493.70
JUL		103.00		103.00
AUG		184.21		184.21
SEP		50.00		50.00
OCT	39.64			39.64
NOV	204.51			204.51
DEC	254.52		78.00	332.52
-----	-----	-----	-----	-----
TOTAL	498.67	1,544.29	156.00	2,198.96
=====				
GASOLINE FOR FACILITY BANKING, MAINTENANCE, MARKETING AND ACTIVITIES				

HILLCREST HEALTHCARE CENTER, INC PROFESSIONAL FEE SCHEDULE 12/31/05		
CAREPLUS MANAGEMENT	DATA PROCESSING	13,200
E-HEALTH DATA SOLUTIONS	DATA PROCESSING	2,757
ACHIEVE	DATA PROCESSING	3,472
NATIONAL DATA CARE	DATA PROCESSING	3,537
AMERICAN DATA MAINGENANCE	DATA PROCESSING	3,960
CAREPLUS MANAGEMENT	ADMINISTRATIVE CONSULTANT	193,000
KRUPNICK, BOKOR, KAGDA & BROOKS	ACCOUNTING	36,150
MEYER MAGENCE	LEGAL	2,885
SACHNOFF & WEAVER	LEGAL	373
RICHARD PEELO	MEDICARE COST REPORTING	4,800
ECONOCARE	PURCHASING CONSULTANT	2,772
PERSONNEL PLANNERS	UC CONSULTANT	1,945

		268,850
		=====

HILLCREST HEALTHCARE CENTER INC EDUCATION & SEMINAR 12/31/05						
ACCT #18180						
DATE	INV	SPONSOR OF SEMINAR	SEMINAR PURPOSE	EMPLOYEE	LOC	COST

4.05		IHCA	SEMINAR		IL	595.00
9.05		PESI HEALTHCARE	ASSESSMENT/TREATMT BORDERLINE PERSONALITY DISORDER	AMY WALKO, KARLA ISMAY	IL	330.00
12.05		TRITON COLLEGE	REHAB NURSING COURSE	DONNA OLSON, STELLA BRASS	IL	1,150.00
-----						-----
TOTAL						2,075.00
=====						

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

#0037572

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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			35,659	35,659		35,659	23,027	58,686			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			106,695	106,695		106,695	56,112	162,807			32
33	Real Estate Taxes			76,165	76,165		76,165		76,165			33
34	Rent-Facility & Grounds			621,972	621,972		621,972		621,972			34
35	Rent-Equipment & Vehicles			62,160	62,160		62,160	(27,472)	34,688			35
36	Other (specify):*											36
37	TOTAL Ownership			902,651	902,651		902,651	51,667	954,318			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		40,563	9,546	50,109		50,109	(968)	49,141			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			91,980	91,980		91,980		91,980			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		40,563	101,526	142,089		142,089	(968)	141,121			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,510,873	442,401	2,649,894	5,603,168		5,603,168	(410,417)	5,192,751			45

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

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

0037572

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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	6,980	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	(206)	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	(51,496)	21		18
19	Entertainment				19
20	Contributions	(500)	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	(1,178)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,802)	20		28
29	Other-Attach Schedule <u>DEFERRED MAINT</u>	1,170	6		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (48,232)		\$	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)	(362,185)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (362,185)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (410,417)		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: 01/01/2005

Ending: 12/31/2005

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	DEFERRED MAINTENANCE	\$ 1,170	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	1,170	49

STATE OF ILLINOIS

Summary A

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

01/01/2005

Ending: 12/31/2005

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(206)	0	0	0	0	0	0	0	0	0	0	(206)	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	53	0	0	0	0	0	0	0	0	0	53	5
6	Maintenance	1,170	6,898	0	0	0	0	0	0	0	0	0	8,068	6
7	Other (specify):*	0	41	0	0	0	0	0	0	0	0	0	41	7
8	TOTAL General Services	964	6,992	0	0	0	0	0	0	0	0	0	7,956	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	(92,600)	0	0	0	0	0	0	0	0	0	(92,600)	10
10a	Therapy	0	3,100	(2,537)	0	0	0	0	0	0	0	0	563	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	(89,500)	(2,537)	0	(92,037)	16							
	C. General Administration													
17	Administrative	0	(180,000)	101,565	0	0	0	0	0	0	0	0	(78,435)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(206,200)	5,400	0	0	0	0	0	0	0	0	(200,800)	19
20	Fees, Subscriptions & Promotions	(4,680)	0	4,016	0	0	0	0	0	0	0	0	(664)	20
21	Clerical & General Office Expenses	(51,496)	(198,099)	85,076	0	0	0	0	0	0	0	0	(164,519)	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	1,401	0	0	0	0	0	0	0	0	1,401	23
24	Travel and Seminar	0	0	272	0	0	0	0	0	0	0	0	272	24
25	Other Admin. Staff Transportation	0	0	3,108	0	0	0	0	0	0	0	0	3,108	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,577	0	0	0	0	0	0	0	0	1,577	26
27	Other (specify):*	0	0	61,025	0	0	0	0	0	0	0	0	61,025	27
28	TOTAL General Administration	(56,176)	(584,299)	263,440	0	(377,035)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(55,212)	(666,807)	260,903	0	(461,116)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number HILLCREST HEALTHCARE CENTER

0037572

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	6,980	0	16,047	0	0	0	0	0	0	0	0	23,027	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	56,112	0	0	0	0	0	0	0	0	56,112	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	(27,472)	0	0	0	0	0	0	0	0	(27,472)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	6,980	0	44,687	0	51,667	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	(968)	0	0	0	0	0	0	0	0	(968)	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	(968)	0	(968)	44							
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(48,232)	(666,807)	304,622	0	(410,417)	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	21	HOME OFFICE EXPENSE	97,299	" "			(97,299)	5
6	V	10	M/C,PA,PSYCH FEES	125,000	" "			(125,000)	6
7	V								7
8	V	5	ELECTRICITY		" "		53	53	8
9	V	6	REPAIRS		" "		2,567	2,567	9
10	V	6	MAINTENANCE SALARIES		" "		4,331	4,331	10
11	V	7	SECURITY		" "		41	41	11
12	V	10	NURSING		" "		32,400	32,400	12
13	V	10a	THERAPY SALARIES		" "		3,100	3,100	13
14	Total		\$ 709,299				\$ 42,492	\$ * (666,807)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	17 ADMIN SALARIES	\$	CAREPLUS MGMT INC		\$ 101,565	\$	101,565	15
16	V	19 PROFESSIONAL FEES		" "		5,400		5,400	16
17	V	20 DUES/LICENSES/WANT ADS		" "		4,016		4,016	17
18	V	21 OFFICE EXPENSES		" "		31,753		31,753	18
19	V	21 CLERICAL SALARIES		" "		53,323		53,323	19
20	V	23 SEMINARS		" "		1,401		1,401	20
21	V	24 TRAVEL		" "		272		272	21
22	V	25 TRANSPORTATION		" "		3,108		3,108	22
23	V	26 INSURANCE		" "		1,577		1,577	23
24	V	27 EMPLOYEE BENEFITS		" "		61,025		61,025	24
25	V	30 SL DEPRECIATION		" "		11,080		11,080	25
26	V	32 INTEREST		" "		52,065		52,065	26
27	V	35 EQUIP RENT/AUTO LEASE		" "		7,263		7,263	27
28	V								28
29	V								29
30	V	10a THERAPY SERVICES	44,078	CAREPLUS REHABILITATIVE SERVICES		41,541		(2,537)	30
31	V	39 ANCILLARY THERAPY	9,545	" "		8,577		(968)	31
32	V	35 EQUIPMENT RENT EXPENSE	34,735	" "				(34,735)	32
33	V	30 SL DEPRECIATION		" "		4,967		4,967	33
34	V	32 INTEREST		" "		4,047		4,047	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 88,358			\$ 392,980	\$ *	304,622	39

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

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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	5.6	9.31	SALARY	18,610	17-7	2
3	JAKOB BAKST	DIR OPERATIONS	ADMIN/CONS.	34.67	SCHEDULES	5.6	9.31	" "	18,610	17-7	3
4	JOE ZIMMERMAN	CFO	FINANCE	0.60	" "	5.6	9.31	" "	12,014	17-7	4
5	JANICE CLAFFORD	A/R MGR	A/R MGMT	0.60	" "	5.6	9.31	" "	5,914	17-7	5
6	ROMY MACASAET	RN CONSULT.	NURSING	0.60	" "	5.6	9.31	" "	1,553	10-7	6
7	JAMEE O'BRIEN	REGIONAL DIR.	ADMIN	0.60	" "	5.6	9.31	" "	11,864	17-7	7
8	ROSLYN INDICH	EXECUTIVE ASST	A/P MGMT	2.38	" "	5.6	9.31	" "	1,531	17-7	8
9											9
10	HUNTER MGMT LLC -- ERIC ROTHNER		MGMT	21.13	" "			MGMT FEES	55,000	17-3	10
11											11
12											12
13								TOTAL	\$ 125,096		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:

01/01/2005

Ending: 2/31/2005

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		CENSUS DAYS			\$	\$		\$	1
2	5	ELECTRICITY	553,765	13 FACILITIES	574		51,528	53	2
3	6	REPAIRS	553,765	13 FACILITIES	27,588		51,528	2,567	3
4	6	MAINTENANCE SALARIES	553,765	13 FACILITIES	46,540	46,540	51,528	4,331	4
5	7	SECURITY	553,765	13 FACILITIES	444		51,528	41	5
6	10	NURSING	553,765	13 FACILITIES	348,203	348,203	51,528	32,400	6
7	10a	THERAPY SALARIES	553,765	13 FACILITIES	33,317	33,317	51,528	3,100	7
8	17	ADMIN SALARIES	553,765	13 FACILITIES	1,091,504	1,091,504	51,528	101,565	8
9	19	PROFESSIONAL FEES	553,765	13 FACILITIES	58,031		51,528	5,400	9
10	20	DUES/LICENSES/WANT ADS	553,765	13 FACILITIES	43,163		51,528	4,016	10
11	21	OFFICE EXPENSES	553,765	13 FACILITIES	341,243		51,528	31,753	11
12	21	CLERICAL SALARIES	553,765	13 FACILITIES	573,059	573,059	51,528	53,323	12
13	23	SEMINARS	553,765	13 FACILITIES	15,061		51,528	1,401	13
14	24	TRAVEL	553,765	13 FACILITIES	2,923		51,528	272	14
15	25	TRANSPORTATION	553,765	13 FACILITIES	33,401		51,528	3,108	15
16	26	INSURANCE	553,765	13 FACILITIES	16,951		51,528	1,577	16
17	27	EMPLOYEE BENEFITS	553,765	13 FACILITIES	655,825		51,528	61,025	17
18	30	SL DEPRECIATION	553,765	13 FACILITIES	119,076		51,528	11,079	18
19	32	INTEREST	553,765	13 FACILITIES	559,538		51,528	52,065	19
20	35	EQUIP RENT/AUTO LEASE	553,765	13 FACILITIES	78,057		51,528	7,263	20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 4,044,498	\$ 2,092,623		\$ 376,339	25

Facility Name & ID Number

HILLCREST HEALTHCARE CENTER

0037572

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	A. Directly Facility Related																	
	Long-Term																	
1	CAREPLUS MANAGEMENT ALLOCATION: LOC, ETC						\$	\$				\$ 52,065	1					
2	CAREPLUS REHAB ALLOCATION: EQUIPMENT LOANS											4,047	2					
3													3					
4													4					
5	CAREPLUS MGMT - CIB BK	X		CAPITAL IMPROVEMENT	\$5,572.35	01/04	234,551	169,214	01/09	PRIME+		60,789	5					
	Working Capital																	
6	CAREPLUS MGMT - HFG	X		WORKING CAPITAL	DEMAND	Nov-99	1,925,000	587,767		PRIME+		45,441	6					
7	INSURANCE FINANCING		X	INSUR. FINANCE								465	7					
8													8					
9	TOTAL Facility Related				\$5,572.35		\$ 2,159,551	\$ 756,981				\$ 162,807	9					
	B. Non-Facility Related*																	
10													10					
11													11					
12													12					
13													13					
14	TOTAL Non-Facility Related						\$	\$				\$	14					
15	TOTALS (line 9+line14)						\$ 2,159,551	\$ 756,981				\$ 162,807	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 2004 report.	\$	72,040	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.)	\$	73,735	2
3. Under or (over) accrual (line 2 minus line 1).	\$	1,695	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	74,470	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.	\$	76,165	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2000	64,403	8
	2001	66,911	9
	2002	71,585	10
	2003	71,328	11
	2004	73,735	12

FOR OHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2004	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

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

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 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 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 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 2004 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 2004.

(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>73,734.64</u>	\$ <u>73,734.64</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>73,734.64</u>	\$ <u>73,734.64</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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number HILLCREST HEALTHCARE CENTER

0037572

Report Period Beginning:

01/01/2005 Ending:

12/31/2005

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, CNA 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>		\$	<u>1</u>
2					<u>2</u>
3	TOTALS	132,928		\$	3

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

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

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		2,806	9
10		LEASEHOLD IMPROVEMENTS		1992	48,072	1,525	31.5	1,526	1	20,601	10
11		LEASEHOLD IMPROVEMENTS		1993	33,291	981	31.5	1,057	76	13,212	11
12		LEASEHOLD IMPROVEMENTS		1994	10,172	261	39	261		2,969	12
13		ROOF REPAIR		1995	5,221	134	39	134		1,379	13
14		CONDENSING UNITS		1996	3,924	101	39	101		972	14
15		CEILING TILES		1996	1,334	34	39	34		322	15
16		ROOF REPAIR		1996	8,079	207	39	207		1,941	16
17		DOORS		1997	1,078	28	39	28		239	17
18		WINDOWS & ROOF VENTILATOR		1997	3,572	92	39	92		740	18
19		WINDOWS		1998	12,100	309	39	310	1	2,357	19
20		ROOF REPAIRS/DOORS/ELEC. REPAIRS/LOT LIGHTS		1998	23,693	607	39	607		4,589	20
21		WALLCOVER/RAILS/NURSE STNS/WINDOW TREATMENTS		1998	155,436	3,985	39	3,985		29,792	21
22		WINDOWS/DECORATING/CEILING TILE/ROOF REPAIR		1999	70,751	1,814	39	1,814		11,836	22
23		WINDOWS/FLOORING/DOOR		2000	12,169	442	27.5	442		2,492	23
24		CARPETING		2000	2,088	186	10	209	23	1,149	24
25		DOORS/ELEVATOR REPAIRS/SECURITY SYSTEM UPGRADE		2001	42,268	1,536	27.5	1,537	1	7,253	25
26		FENCE		2001	10,361	691	15	691		3,109	26
27		ROOF REPAIRS/CEILING TILE/FIRE DAMPERS/LIGHTING		2001	43,148	1,568	27.5	1,569	1	6,579	27
28		ROOF REPAIRS/HEAT/AC REPAIRS		2002	12,346	450	27.5	449	(1)	1,530	28
29		FENCE		2002	4,573	305	15	305		1,067	29
30		DOOR REPLACEMENTS/DUCTWORK-FIRE CODE		2003	7,297	266	27.5	265	(1)	709	30
31		DURO-LAST ROOF SYSTEM		2003	66,500	3,355	27.5	3,355		7,596	31
32		WALL A/C UNIT INSTALLATIONS / ELEVATOR BUTTONS		2003	92,265	2,418	27.5	2,418		5,743	32
33		FENCE / PARKING LOT SEAL		2003	8,816	588	15	588		1,470	33
34		EXTERIOR DOORS		2004	2,807	102	27.5	102		166	34
35		BATHROOM REMODELING		2004	2,500	91	27.5	91		140	35
36		SPRINKLERS/PIPING		2004	1,881	68	27.5	68		99	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	2	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	WALL UNIT A/C	2005	\$ 7,074	\$ 220	27.5	\$ 220	\$	\$ 220	37
38	BATHROOMS/KITCHEN REMODELING	2005	51,970	1,019	27.5	1,019		1,019	38
39	FIRE ALARM SYSTEM	2005	61,833	1,452	27.5	1,452		1,452	39
40									40
41									41
42									42
43									43
44	RELATED PARTY ALLOCATION - CAREPLUS REHAB								44
45	WALL UNIT A/C'S,BRICKWORK,DRYWALL,ELECTRICAL	2004	29,464	756	39	756		1,354	45
46	CEILINGS/DRYWALL	2004	6,913	178	39	178		322	46
47	FIRE DAMPERS/DUCTWORK	2004	10,058	258	39	258		364	47
48									48
49									49
50	RELATED PARTY ALLOCATION - CAREPLUS MGMT								50
51	BUILDING-TAG-18 PROPERTIES	2004	58,244	1,493	39	1,493			51
52	BUILDING IMPROVEMENTS-TAG-18 PROPERTIES	2004	22,882	881	39	881			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)		\$ 940,410	\$ 28,599		\$ 28,700	\$ 101	\$ 137,588	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	\$ 202,748	\$ 10,209	\$ 17,375	\$ 7,166	8-15 YRS	\$ 118,550	71
72	Current Year Purchases	2,087	417	130	(287)	8 YRS	130	72
73	Fully Depreciated Assets							73
74	** RELATED PARTY - SL DEPN: CAREPLUS MGMT, 8706, CAREPLUS REHAB, 3775		12,481	12,481		8-15 YRS		74
75	TOTALS	\$ 204,835	\$ 23,107	\$ 29,986	\$ 6,879		\$ 118,680	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)	\$ 1,145,245	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 51,706	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 58,686	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,980	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 256,268	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:	168	09/15/91	\$ 621,972	15		3
4	Additions						4
5							5
6							6
7	TOTAL	168		\$ 621,972			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: \$ **53,268** 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	ACTIVITY/HSKP/	FACILITY FORD VAN	\$ 683.10	\$ 8,892	17
18	MAINT				18
19					19
20					20
21	TOTAL		\$ 683.10	\$ 8,892	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. 2006 \$ _____

13. 2007 \$ _____

14. 2008 \$ _____

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
<p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>		

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$				1
2	Licensed Speech and Language Development Therapist	39-3	hrs			109			109	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			9,437			9,437	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				39,621		39,621	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					942		942	13
14	TOTAL			\$		\$ 9,546	\$ 40,563		\$ 50,109	14

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

Facility Name & ID Number HILLCREST HEALTHCARE CENTER

0037572

Report Period Beginning: 01/01/2005

Ending:

12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2005

(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>110,000</u>)	1,577,937		3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	131,642		6
7	Other Prepaid Expenses	47,860		7
8	Accounts Receivable (owners or related parties)	25,000		8
9	Other(specify): <u>R.E,TAX ESCROW</u>	45,602		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,828,041	\$	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	812,848		15
16	Equipment, at Historical Cost	204,834		16
17	Accumulated Depreciation (book methods)	(328,246)		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)	\$ 690,802	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,518,843	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 595,588	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	587,767		29
30	Accrued Salaries Payable	149,077		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,792		31
32	Accrued Real Estate Taxes(Sch.IX-B)	74,470		32
33	Accrued Interest Payable	12,370		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)	\$ 1,432,064	\$	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)	\$ 1,601,278	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 917,565	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,518,843	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 528,678	1
2	Restatements (describe):		2
3	POST-CLOSING FURNISHINGS/DEPRECIATION ADJ	2,358	3
4	BAD DEBTS	(69,138)	4
5	ROUNDING	5	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 461,903	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	455,662	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)	\$ 455,662	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)	\$ 917,565	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	\$ 6,058,830	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,058,830	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,058,830	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	995,373	31
32	Health Care	2,069,384	32
33	General Administration	1,493,671	33
	B. Capital Expense		
34	Ownership	902,651	34
	C. Ancillary Expense		
35	Special Cost Centers	50,109	35
36	Provider Participation Fee	91,980	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,603,168	40
41	Income before Income Taxes (line 30 minus line 40)**	455,662	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 455,662	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: 01/01/2005

Ending: 12/31/2005

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	2,120	2,360	\$ 70,580	\$ 29.91	1
2	Assistant Director of Nursing	2,006	2,156	56,478	26.20	2
3	Registered Nurses	12,028	12,749	317,007	24.87	3
4	Licensed Practical Nurses	20,132	21,519	462,221	21.48	4
5	CNAs & Orderlies	40,916	45,211	400,568	8.86	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,071	5,989	63,838	10.66	8
9	Activity Director	2,079	2,388	45,278	18.96	9
10	Activity Assistants	6,655	7,421	55,435	7.47	10
11	Social Service Workers	15,678	16,690	279,082	16.72	11
12	Dietician					12
13	Food Service Supervisor	1,881	1,961	32,724	16.69	13
14	Head Cook	6,490	7,113	59,254	8.33	14
15	Cook Helpers/Assistants	11,002	12,108	85,486	7.06	15
16	Dishwashers					16
17	Maintenance Workers	3,771	4,093	42,928	10.49	17
18	Housekeepers	15,098	16,567	126,914	7.66	18
19	Laundry	8,275	9,062	68,600	7.57	19
20	Administrator	2,734	2,939	55,231	18.79	20
21	Assistant Administrator	1,726	1,856	34,869	18.79	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,060	9,808	169,781	17.31	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	2,307	2,526	29,734	11.77	31
32	Other Health Care(specify)					32
33	Other(specify) <u>SECURITY</u>	6,675	7,025	54,865	7.81	33
34	TOTAL (lines 1 - 33)	175,704	191,541	\$ 2,510,873 *	\$ 13.11	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	\$ 9,098	1-3	35
36	Medical Director	O	20,300	9-3	36
37	Medical Records Consultant	N	4,899	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	2,352	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	<u>PSYCHIATRIC</u>		100,000	10-3	47
48	<u>M/C & PA CONSULTING</u>		25,000	10-3	48
49	TOTAL (lines 35 - 48)		\$ 172,449		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		\$		53

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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2002	FY2003	FY2004	FY2005
1	PAINT/DECORATING	2002	\$ 7,025	3	\$ 1,171	\$ 2,342	\$ 2,342	\$ 1,170	\$	\$	\$	\$								
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20	TOTALS		\$ 7,025		\$ 1,171	\$ 2,342	\$ 2,342	\$ 1,170	\$	\$	\$	\$								

Facility Name & ID Number HILLCREST HEALTHCARE CENTER# 0037572Report Period Beginning: 01/01/2005Ending: 12/31/2005**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? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 169 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 91,980
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, 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. \$ 13,140 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