

Facility Name & ID Number HILLCREST HEALTHCARE CENTER

0037572 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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			798	798	8
9	SNF/PED					9
10	ICF	52,424	1,312		53,736	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	52,424	1,312	798	54,534	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.93%

D. How many bed-hold days during this year were paid by the Department? 1,332 (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 798

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number **HILLCREST HEALTHCARE CENTER** # **0037572** Report Period Beginning: **01/01/2006** Ending: **12/31/2006**

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	181,097	19,061	9,574	209,732		209,732	0	209,732		1
2	Food Purchase		221,754		221,754	(13,907)	207,847	(511)	207,336		2
3	Housekeeping	149,506	32,140	0	181,646		181,646	0	181,646		3
4	Laundry	56,427	14,369	300	71,096	0	71,096	0	71,096		4
5	Heat and Other Utilities			124,409	124,409		124,409	40	124,449		5
6	Maintenance	30,746	17,981	61,268	109,995		109,995	6,598	116,593		6
7	Other (specify):* SECURITY	49,925		17,827	67,752		67,752	19	67,771		7
8	TOTAL General Services	467,701	305,305	213,378	986,384	(13,907)	972,477	6,146	978,623		8
	B. Health Care and Programs										
9	Medical Director	0		23,700	23,700		23,700	0	23,700		9
10	Nursing and Medical Records	1,385,513	65,305	79,139	1,529,957		1,529,957	(20,403)	1,509,554		10
10a	Therapy	53,079	1,161	32,736	86,976		86,976	(661)	86,315		10a
11	Activities	93,762	35,067	0	128,829		128,829	0	128,829		11
12	Social Services	269,712		0	269,712		269,712	0	269,712		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			40	40		40	0	40		14
15	Other (specify):*			0	0		0	0	0		15
16	TOTAL Health Care and Programs	1,802,066	101,533	135,615	2,039,214	0	2,039,214	(21,064)	2,018,150		16
	C. General Administration										
17	Administrative	80,468		235,000	315,468		315,468	(70,095)	245,373		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			240,278	240,278		240,278	(177,544)	62,734		19
20	Dues, Fees, Subscriptions & Promotions			12,794	12,794		12,794	(2,381)	10,413		20
21	Clerical & General Office Expenses	182,174	20,572	220,070	422,816		422,816	(103,236)	319,580		21
22	Employee Benefits & Payroll Taxes			380,018	380,018	13,907	393,925	0	393,925		22
23	Inservice Training & Education			2,289	2,289		2,289	2,178	4,467		23
24	Travel and Seminar			319	319		319	1,165	1,484		24
25	Other Admin. Staff Transportation			9,878	9,878		9,878	3,209	13,087		25
26	Insurance-Prop.Liab.Malpractice			87,841	87,841		87,841	1,554	89,395		26
27	Other (specify):*			0	0		0	62,208	62,208		27
28	TOTAL General Administration	262,642	20,572	1,188,487	1,471,701	13,907	1,485,608	(282,942)	1,202,666		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,532,409	427,410	1,537,480	4,497,299	0	4,497,299	(297,860)	4,199,439		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	8,914
	REPAIRS & MAINTENANCE	660
		0
		9,574
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	300
		0
		300
5	HEAT & OTHER UTILITIES	
	GAS HEAT	14,355
	ELECTRICITY	64,184
	WATER	31,854
	CABLE TV - LOBBY	14,016
		0
		124,409
6	MAINTENANCE	
	GROUNDS MAINTENANCE	7,835
	PAINTING & DECORATING	0
	BUILDING REPAIRS	3,177
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	24,095
	ELEVATOR MAINTENANCE & REPAIR	13,668
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,745
	FIRE SERVICE	8,748
		0
		0
		0
		0
		61,268
7	OTHER	
	SCAVENGER	17,827
	SECURITY SERVICE	0
		0
		0
		17,827
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	23,700
		23,700

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	1,180
	PURCHASED SERVICES	1,710
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	2,326
	PHARMACY CONSULTANT XVIII B 39-2	2,016
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B 47-2	0
	RN CONSULTANT XVIII B 38-2	0
	DENTAL SERVICES	2,800
	MEDICARE & PUBLIC AID CONSULTAN XVIII B 48-2	69,107
		79,139
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	3,254
	SPEECH THERAPY SERVICES	149
	OCCUPATIONAL THERAPY SERVICES	2,408
	REHABILITATION CONSULTANT XVIII B ___-2	0
	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
	THERAPY CONTRACT SERVICES	16,125
		32,736
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	40
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	235,000
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	27,254
	ADMINISTRATIVE CONSULTANTS XIX C	168,000
	PROFESSIONAL FEES XIX C	45,024
		0
		240,278
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	4,365
	EMPLOYEE WANT ADS XIX F	3,732
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	660
	LICENSES & PERMITS XIX F	3,010
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	375
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	300
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	352
	PATIENT BACKGROUND CHECKS XIX F	0
		0
		12,794
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	7,009
	OUTSIDE CLERICAL SERVICES	149,547
	PENALTIES / OVERDRAFT CHARGES VI 18	28,940
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	842
	TELEPHONE	32,994
	MESSENGER SERVICE	738
		0
		220,070

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	191,203
	UNEMPLOYMENT COMPENSATION XIX D	42,084
	WORKERS COMPENSATION INSURANC XIX D	71,773
	HOSPITALIZATION INSURANCE XIX D	33,085
	EMPLOYEE BENEFITS - OTHER XIX D	969
	EMPLOYEE PHYSICAL EXAMS XIX D	2,321
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	38,583
	CHICAGO HEAD TAX XIX D	0
		0
		380,018
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	2,289
		2,289
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	319
		319
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	9,878
		9,878
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	87,617
	GENERAL INSURANCE EXPENSE	224
		87,841
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

1,537,480

HILLCREST HEALTHCARE CENTER
 SCHEDULES
 12/31/2006

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

TOTAL FOOD PURCHASE	221,754
LESS SALES TAX	(511)
NET FOOD	221,243
TOTAL PATIENT CENSUS	54,534
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	163,602
ADD # EMPLOYEE MEALS/DAY	30
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	10,950
PATIENT MEALS	163,602
ADD EMPLOYEE MEALS	10,950
TOTAL MEALS/YEAR	174,552
NET FOOD	221,243
DIVIDE TOTAL MEALS/YEAR	174,552
COST PER MEAL	1.27
TIME EMPLOYEE MEALS	10,950
EMPLOYEE MEAL RECLASSIFICATION	13,907
	=====

PROFESSIONAL FEES
 PAGE 21 SCHEDULE XIX PART C

CAREPLUS MGT	DATA PROCESSING	13,200
ACHIEVE HEALTHCARE	DATA PROCESSING	3,659
AMERICAN DATA	DATA PROCESSING	2,702
NATIONAL DATA CARE	DATA PROCESSING	3,150
e-HEALTH DATA SOLUTIONS	DATA PROCESSING	4,516
ADAPTASOFT	DATA PROCESSING	27
CAREPLUS MGT	ADMINISTRATIVE CONSULTANT	168,000
KRUPNICK, BOKOR, KAGDA, LTD	ACCOUNTING	25,950
ABRAHAM A GUTNICKI ESQ	LEGAL	250
MEYER MAGENCE	LEGAL	2,126
KARMEL LAW FIRM	LEGAL	1,086
JOHN D REBIK & ASSOC	SURVEYOR	4,500
APPRAISAL RESEARCH	APPRAISAL	2,250
ECONOCARE	PURCHASING CONSULTANT	2,268
PERSONNEL PLANNER	UC CONSULTANT	1,794
RICHARD PEELO	MEDICARE CONSULTANT	4,800
TOTAL PROFESSIONAL FEES		240,278
		=====

EQUIPMENT RENTAL EXPENSE
 PAGE 14 SCHEDULE XII PART B LINES 15

CAREPLUS REHAB	RELATED PARTY EQUIP RENT	35,323
JOHNSON WATER CONDITION	PLANT EQUIPMENT	240
RENTAL MAX	PLANT EQUIPMENT	34
AIR CLEANING SPECIALISTS	SMOKEETERS	1,180
FAMILY PRIDE	WASHER/DRYER	8,250
GE CAPITAL	COPIER	4,757
TOTAL EQUIPMENT RENTAL EXPENSE		49,784
		=====

TRANSPORTATION - STAFF
 PAGE 3 SCHEDULE V COLUMN 3 LINE 25

	FLEET FUELING	CAR ALLOW	SEC STATE	A.WALKO P/C	A.HUNT P/C	G.DORAN P/C	TOTAL
JAN							
FEB					473	21	
MAR							
APR							
MAY							
JUN			98	255			
JUL							
AUG							
SEP				303			
OCT				368			
NOV							
DEC	4,252	3,602		467		39	
TOTAL	4,252	3,602	98	1,866	21	39	9,878
	=====						
	GASOLINE FOR FACILITY BANKING, MAINTENANCE, MARKETING, AND ACTIVITIES						

EDUCATION & SEMINARS
 PAGE 3 SCHEDULE V COLUMN 3 LINE 23

DATE	SPONSOR OF SEMINAR	PURPOSE OF SEMINAR	PERSONNEL ATTENDING	LOC	COST OF SEMINAR
JAN 06	AMERICAN RED CROSS	CPR TRAINING	9 EMPLOYEES	IL	76
MAR 06	ICLTC	MDS TRAINING	BRUCE SIMONSON	IL	360
			MAUREEN PRESTEGAARD		
			AURORA PEREZ		
APR 06	CAREER TRACK	SUPERVISOR TRAINING	AMY WALKO	IL	149
	CLINICAL SOLUTIONS LLC	IMPLEMENT MDS SECTION S	AMY WALKO	IL	99
	ICLTC	SKILLS TRAINING FOR PSYCHIATRIC REHAB	CARRIE THERRIEN	IL	235
	ICLTC	NEW 2006 CHANGES TO THE OBRA SURVEY	CARRIE THERRIEN	IL	290
			AMY WALKO		
	ICLTC	SUCCESS ORIENTED APPROACHES TO BEHAVIORAL CHALLENGES IN DEMENTIA	CARRIE THERRIEN	IL	145
AUG 06	HEALTHCARE INFORMATION	PSYCHOSOCIAL OUTCOMES SEVERITY GUIDE	JACKIE MILLER	IL	159
OCT 06	RESTORATIVE MEDICAL	HOW TO MAXIMIZE REIMB & QUALITY OF CARE	JACKIE MILLER	IL	198
			MAUREEN PRESTEGNARD		
NOV 06	ICLTC	STANDARDIZED ADMISSIONS PACKET		IL	128
	AMERICAN EXPRESS			IL	450
					=====
			TOTAL EDUCATION & SEMINARS		2,289
					=====

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

#0037572

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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			42,791	42,791		42,791	21,839	64,630			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			74,657	74,657		74,657	39,781	114,438			32
33	Real Estate Taxes			74,067	74,067		74,067	4,911	78,978			33
34	Rent-Facility & Grounds			691,972	691,972		691,972	0	691,972			34
35	Rent-Equipment & Vehicles			65,246	65,246		65,246	(26,212)	39,034			35
36	Other (specify):*				0		0	0	0			36
37	TOTAL Ownership			948,733	948,733	0	948,733	40,319	989,052			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		15,216	14,865	30,081		30,081	(1,795)	28,286			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			91,980	91,980		91,980	0	91,980			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	15,216	106,845	122,061	0	122,061	(1,795)	120,266			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,532,409	442,626	2,593,058	5,568,093	0	5,568,093	(259,336)	5,308,757			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:

01/01/2006

Ending:

12/31/2006

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	4,667	30		9
10	Interest and Other Investment Income	(88)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(511)	2		13
14	Non-Care Related Interest	(209)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(375)	20		17
18	Fines and Penalties	(28,940)	21		18
19	Entertainment				19
20	Contributions	(300)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,365)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (30,121)		\$ 0	30

BHF USE ONLY					
48	49	50	51	52	

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(229,215)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (229,215)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (259,336)		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: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	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	0	49

STATE OF ILLINOIS

Summary A

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

01/01/2006

Ending: 12/31/2006

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	(511)	0	0	0	0	0	0	0	0	0	0	(511)	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	40	0	0	0	0	0	0	0	0	0	40	5
6	Maintenance	0	6,598	0	0	0	0	0	0	0	0	0	6,598	6
7	Other (specify):*	0	19	0	0	0	0	0	0	0	0	0	19	7
8	TOTAL General Services	(511)	6,657	0	0	0	0	0	0	0	0	0	6,146	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	(20,403)	0	0	0	0	0	0	0	0	0	(20,403)	10
10a	Therapy	0	3,293	(3,954)	0	0	0	0	0	0	0	0	(661)	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	(17,110)	(3,954)	0	(21,064)	16							
	C. General Administration													
17	Administrative	0	(180,000)	109,905	0	0	0	0	0	0	0	0	(70,095)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(181,200)	3,656	0	0	0	0	0	0	0	0	(177,544)	19
20	Fees, Subscriptions & Promotions	(5,040)	0	2,659	0	0	0	0	0	0	0	0	(2,381)	20
21	Clerical & General Office Expenses	(28,940)	(149,547)	75,251	0	0	0	0	0	0	0	0	(103,236)	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	2,178	0	0	0	0	0	0	0	0	2,178	23
24	Travel and Seminar	0	0	1,165	0	0	0	0	0	0	0	0	1,165	24
25	Other Admin. Staff Transportation	0	0	3,209	0	0	0	0	0	0	0	0	3,209	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,554	0	0	0	0	0	0	0	0	1,554	26
27	Other (specify):*	0	(10,612)	72,820	0	0	0	0	0	0	0	0	62,208	27
28	TOTAL General Administration	(33,980)	(521,359)	272,397	0	(282,942)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(34,491)	(531,812)	268,443	0	(297,860)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	4,667	0	17,172	0	0	0	0	0	0	0	0	21,839	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(297)	0	40,078	0	0	0	0	0	0	0	0	39,781	32
33	Real Estate Taxes	0	0	4,911	0	0	0	0	0	0	0	0	4,911	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	(26,212)	0	0	0	0	0	0	0	0	(26,212)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	4,370	0	35,949	0	40,319	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	(1,795)	0	0	0	0	0	0	0	0	(1,795)	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	(1,795)	0	(1,795)	44							
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(30,121)	(531,812)	302,597	0	(259,336)	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		
					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	168,000	" "			(168,000)	2
3	V	19	DATA PROCESSING FEES	13,200	" "			(13,200)	3
4	V	21	CLERICAL FEES	149,547	" "			(149,547)	4
5	V	27	W/C INSURANCE	10,612	" "			(10,612)	5
6	V	10	PROGAM CONSULTANT FEES	69,107	" "			(69,107)	6
7	V								7
8	V	5	UTILITIES		" "		40	40	8
9	V	6	REPAIRS		" "		1,648	1,648	9
10	V	6	MAINTENANCE SALARIES		" "		4,950	4,950	10
11	V	7	SECURITY		" "		19	19	11
12	V	10	NURSING		" "		48,704	48,704	12
13	V	10a	THERAPY SALARIES		" "		3,293	3,293	13
14	Total		\$ 590,466				\$ 58,654	\$ * (531,812)	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		\$ 109,905	\$	109,905	15
16	V	19 PROFESSIONAL FEES		" "		3,656		3,656	16
17	V	20 DUES/LICENSES/WANT ADS		" "		2,659		2,659	17
18	V	21 OFFICE EXPENSES		" "		16,218		16,218	18
19	V	21 CLERICAL SALARIES		" "		59,033		59,033	19
20	V	23 SEMINARS		" "		2,178		2,178	20
21	V	24 TRAVEL		" "		1,165		1,165	21
22	V	25 TRANSPORTATION		" "		3,209		3,209	22
23	V	26 INSURANCE		" "		1,554		1,554	23
24	V	27 EMPLOYEE BENEFITS		" "		72,820		72,820	24
25	V	30 SL DEPRECIATION		" "		12,205		12,205	25
26	V	32 INTEREST		" "		35,470		35,470	26
27	V	33 REAL ESTATE TAX		" "		4,911		4,911	27
28	V	35 EQUIP RENT/AUTO LEASE		" "		9,111		9,111	28
29	V								29
30	V	10a THERAPY SERVICES	32,734	CAREPLUS REHABILITATIVE SERVICES		28,780		(3,954)	30
31	V	39 ANCILLARY THERAPY	14,864	" "		13,069		(1,795)	31
32	V	35 EQUIPMENT RENT EXPENSE	35,323	" "				(35,323)	32
33	V	30 SL DEPRECIATION		" "		4,967		4,967	33
34	V	32 INTEREST		" "		4,608		4,608	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 82,921			\$ 385,518	\$ *	302,597	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: 01/01/2006 Ending: 12/31/2006

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CAREPLUS MGMT ALLOCATIONS:							\$		1	
2	SHERWIN RAY	PRESIDENT	ADMIN/FINANCE	25.30	SEE ATTACHED	5.9	9.86	SALARY	19,716	17-7	2
3	JAKOB BAKST	DIR OPERATIONS	ADMIN/CONS.	24.70	SCHEDULES	5.9	9.86	" "	19,716	17-7	3
4	JAMEE O'BRIEN	REGIONAL DIR.	ADMIN	0.60	" "	5.9	9.86	" "	13,591	17-7	4
5	ROSLYN INDICH	EXECUTIVE ASST	A/P MGMT	2.38	" "	5.9	9.86	" "	4,857	17-7	5
6	JOE ZIMMERMAN	CFO	FINANCE	0.60	" "	5.9	9.86	" "	9,907	17-7	6
7								" "			7
8											8
9											9
10	HUNTER MGMT LLC -- ERIC ROTHNER		MGMT	3.27	" "			MGMT FEES	55,000	17-3	10
11											11
12											12
13								TOTAL	\$ 122,787		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:

01/01/2006

Ending: 2/31/2006

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 8320 SKOKIE BLVD
 City / State / Zip Code SKOKIE, IL 60077
 Phone Number (847)329-1555
 Fax Number (847)329-9555

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	UTILITIES	553,205	13 FACILITIES	408		54,534	40	2
3	6	REPAIRS	553,205	13 FACILITIES	16,722		54,534	1,648	3
4	6	MAINTENANCE SALARIES	553,205	13 FACILITIES	50,215	50,215	54,534	4,950	4
5	7	SECURITY	553,205	13 FACILITIES	194		54,534	19	5
6	10	NURSING	553,205	13 FACILITIES	494,063	494,063	54,534	48,704	6
7	10a	THERAPY SALARIES	553,205	13 FACILITIES	33,400	33,400	54,534	3,293	7
8	17	ADMIN SALARIES	553,205	13 FACILITIES	1,114,897	1,114,897	54,534	109,905	8
9	19	PROFESSIONAL FEES	553,205	13 FACILITIES	37,085		54,534	3,656	9
10	20	DUES/LICENSES/WANT ADS	553,205	13 FACILITIES	26,974		54,534	2,659	10
11	21	OFFICE EXPENSES	553,205	13 FACILITIES	164,515		54,534	16,218	11
12	21	CLERICAL SALARIES	553,205	13 FACILITIES	598,842	598,842	54,534	59,033	12
13	23	SEMINARS	553,205	13 FACILITIES	22,090		54,534	2,178	13
14	24	TRAVEL	553,205	13 FACILITIES	11,815		54,534	1,165	14
15	25	TRANSPORTATION	553,205	13 FACILITIES	32,553		54,534	3,209	15
16	26	INSURANCE	553,205	13 FACILITIES	15,760		54,534	1,554	16
17	27	EMPLOYEE BENEFITS	553,205	13 FACILITIES	738,700		54,534	72,820	17
18	30	SL DEPRECIATION	553,205	13 FACILITIES	123,804		54,534	12,205	18
19	32	INTEREST	553,205	13 FACILITIES	359,819		54,534	35,470	19
20	33	REAL ESTATE TAX	553,205	13 FACILITIES	49,822		54,534	4,911	20
21	35	EQUIP RENT/AUTO LEASE	553,205	13 FACILITIES	92,424		54,534	9,111	21
22									22
23									23
24									24
25	TOTALS				\$ 3,984,102	\$ 2,291,417		\$ 392,748	25

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

0037572

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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				\$	\$			\$ 35,470	1										
2	CAREPLUS REHAB ALLOCATION: EQUIPMENT LOANS								4,608	2										
3										3										
4										4										
5	CAREPLUS MGT - FIRST BK	X	CAPITAL IMPROVEMENT	\$5,065.78	01/04	213,229	64,349	01/09	PRIME+	6,618	5									
Working Capital																				
6	CAREPLUS MGMT - HFG	X	WORKING CAPITAL	DEMAND	Jan-04	453,000	126,392		PRIME+	66,983	6									
7	INSURANCE FINANCING		INSUR. FINANCE							847	7									
8										8										
9	TOTAL Facility Related			\$5,065.78		\$ 666,229	\$ 190,741			\$ 114,526	9									
B. Non-Facility Related*																				
10	IRS, IDR, ETC		LATE FEES							209	10									
11										11										
12										12										
13										13										
14	TOTAL Non-Facility Related					\$ 0	\$ 0			\$ 209	14									
15	TOTALS (line 9+line14)					\$ 666,229	\$ 190,741			\$ 114,735	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 2005 report.		\$	74,470	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.)		\$	73,897	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(573)	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	74,640	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.		\$	74,067	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	66,911	8
	2002	71,585	9
	2003	71,328	10
	2004	73,735	11
	2005	73,897	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2005	\$	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 2005 TAX BILL.

NOTES:

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

Facility Name & ID Number HILLCREST HEALTHCARE CENTER

0037572

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

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).

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

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

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	LEASEHOLD IMPROVEMENTS		1991	6,230	198	31.5	198		3,004	9
10	LEASEHOLD IMPROVEMENTS		1992	48,072	1,525	31.5	1,526	1	22,127	10
11	LEASEHOLD IMPROVEMENTS		1993	33,291	981	31.5	1,057	76	14,269	11
12	LEASEHOLD IMPROVEMENTS		1994	10,172	261	39	261		3,230	12
13	ROOF REPAIR		1995	5,221	134	39	134		1,513	13
14	CONDENSING UNITS		1996	3,924	101	39	101		1,073	14
15	CEILING TILES		1996	1,334	34	39	34		356	15
16	ROOF REPAIR		1996	8,079	207	39	207		2,148	16
17	DOORS		1997	1,078	28	39	28		267	17
18	WINDOWS & ROOF VENTILATOR		1997	3,572	92	39	92		832	18
19	WINDOWS		1998	12,100	309	39	310	1	2,667	19
20	ROOF REPAIRS/DOORS/ELEC. REPAIRS/LOT LIGHTS		1998	23,693	607	39	607		5,196	20
21	WALLCOVER/RAILS/NURSE STNS/WINDOW TREATMENTS		1998	155,436	3,985	39	3,985		33,777	21
22	WINDOWS/DECORATING/CEILING TILE/ROOF REPAIR		1999	70,751	1,814	39	1,814		13,650	22
23	WINDOWS/FLOORING/DOOR		2000	12,169	442	27.5	442		2,934	23
24	CARPETING		2000	2,088	186	10	209	23	1,358	24
25	DOORS/ELEVATOR REPAIRS/SECURITY SYSTEM UPGRADE		2001	42,268	1,536	27.5	1,537	1	8,790	25
26	FENCE		2001	10,361	691	15	691		3,800	26
27	ROOF REPAIRS/CEILING TILE/FIRE DAMPERS/LIGHTING		2001	43,148	1,568	27.5	1,569	1	8,148	27
28	ROOF REPAIRS/HEAT/AC REPAIRS		2002	12,346	450	27.5	449	(1)	1,979	28
29	FENCE		2002	4,573	305	15	305		1,372	29
30	DOOR REPLACEMENTS/DUCTWORK-FIRE CODE		2003	7,297	266	27.5	265	(1)	974	30
31	DURO-LAST ROOF SYSTEM		2003	66,500	3,355	27.5	3,355		10,951	31
32	WALL A/C UNIT INSTALLATIONS / ELEVATOR BUTTONS		2003	92,265	2,418	27.5	2,418		8,161	32
33	FENCE / PARKING LOT SEAL		2003	8,816	588	15	588		2,058	33
34	EXTERIOR DOORS		2004	2,807	102	27.5	102		268	34
35	BATHROOM REMODELING		2004	2,500	91	27.5	91		231	35
36	SPRINKLERS/PIPING		2004	1,881	68	27.5	68		167	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.

Facility Name & ID Number HILLCREST HEALTHCARE CENTER

0037572

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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	\$ 257	27.5	\$ 257		\$ 477	37
38	BATHROOMS/KITCHEN REMODELING	2005	51,970	1,890	27.5	1,890		2,909	38
39	FIRE ALARM SYSTEM	2005	61,833	2,248	27.5	2,248		3,700	39
40	DOORS	2006	7,026	202	27.5	202		202	40
41	WALL A/C UNITS / SMOKE ROOM EXHAUST / TILE	2006	29,088	603	27.5	540	(63)	540	41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50	RELATED PARTY ALLOCATION - CAREPLUS REHAB								50
51	WALL UNIT A/C'S,BRICKWORK,DRYWALL,ELECTRICAL	2004	29,464	756	39	756		2,110	51
52	CEILINGS/DRYWALL	2004	6,913	178	39	178		500	52
53	FIRE DAMPERS/DUCTWORK	2004	10,058	258	39	258		622	53
54									54
55									55
56	RELATED PARTY ALLOCATION - CAREPLUS MGMT								56
57	BUILDING-TAG-18 PROPERTIES	2004	58,244	1,582	39	1,582		3,075	57
58	BUILDING IMPROVEMENTS-TAG-18 PROPERTIES	2004	22,882	937	39	937		1,818	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)		\$ 976,524	\$ 31,253		\$ 31,291	\$ 38	\$ 171,253	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	\$ 204,835	\$ 6,062	\$ 17,084	\$ 11,022	8-15 YRS	\$ 135,764	71
72	Current Year Purchases	36,614	7,323	1,629	(5,694)	8-15 YRS	1,629	72
73	Fully Depreciated Assets				0			73
74	** RELATED PARTY - SL DEPN: CAREPLUS MGMT, 9,686, CAREPLUS REHAB, 3,775		13,461	13,461	0	8-15 YRS		74
75	TOTALS	\$ 241,449	\$ 26,846	\$ 32,174	\$ 5,328		\$ 137,393	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	FACILITY VAN	'02 DODGE RAM BR150	2006	\$ 9,319	\$ 1,864	\$ 1,165	\$ (699)	4 YRS	\$ 1,165	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 9,319	\$ 1,864	\$ 1,165	\$ (699)		\$ 1,165	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)	\$ 1,227,292	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 59,963	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 64,630	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,667	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 309,811	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	\$ 691,972	15		3
4	Additions						4
5							5
6							6
7	TOTAL	168		\$ 691,972			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: \$ **56,844** 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	\$ 1,342	17
18	MAINT	2002 DODGE RAM		2,529	18
19	MGMT CO ALLOC-SEE ATTACHED			4,531	19
20					20
21	TOTAL		\$ 683.10	\$ 8,402	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. 2007 \$ _____

13. 2008 \$ _____

14. 2009 \$ _____

* 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	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 7,732	\$		\$ 7,732	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			189			189	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			6,944			6,944	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				12,855		12,855	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					2,361		2,361	13
14	TOTAL			\$		\$ 14,865	\$ 15,216		\$ 30,081	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: 01/01/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(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>)	1,786,460		3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	85,233		6
7	Other Prepaid Expenses	63,325		7
8	Accounts Receivable (owners or related parties)	25,000		8
9	Other(specify): <u>R.E.TAX ESCROW</u>	43,704		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,003,722	\$ 0	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	848,962		15
16	Equipment, at Historical Cost	250,768		16
17	Accumulated Depreciation (book methods)	(371,036)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): _____			22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 728,694	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,732,416	\$ 0	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 667,774	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	126,392		29
30	Accrued Salaries Payable	165,378		30
31	Accrued Taxes Payable (excluding real estate taxes)	15,191		31
32	Accrued Real Estate Taxes(Sch.IX-B)	74,640		32
33	Accrued Interest Payable			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)	\$ 1,049,375	\$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	64,349		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)	\$ 64,349	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,113,724	\$ 0	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,611,632	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,725,356	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 917,565	1
2	Restatements (describe):		2
3	ROUNDING	3	3
4	POST-CLOSING INTEREST ADJUSTMENT	36,304	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 953,872	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	657,760	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)	\$ 657,760	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,611,632	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	\$ 6,225,765	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,225,765	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)	\$ 0	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)	\$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	88	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 88	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)	\$ 0	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,225,853	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	986,384	31
32	Health Care	2,039,214	32
33	General Administration	1,471,701	33
	B. Capital Expense		
34	Ownership	948,733	34
	C. Ancillary Expense		
35	Special Cost Centers	30,081	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)*	\$ 5,568,093	40
41	Income before Income Taxes (line 30 minus line 40)**	657,760	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 657,760	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: 01/01/2006

Ending: 12/31/2006

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	2,125	2,299	\$ 71,569	\$ 31.13	1
2	Assistant Director of Nursing	2,173	2,227	60,920	27.36	2
3	Registered Nurses	15,540	16,133	406,290	25.18	3
4	Licensed Practical Nurses	16,958	18,511	404,269	21.84	4
5	CNAs & Orderlies	40,964	45,088	407,594	9.04	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,144	4,892	53,079	10.85	8
9	Activity Director	2,092	2,141	41,730	19.49	9
10	Activity Assistants	6,180	6,810	52,032	7.64	10
11	Social Service Workers	17,045	17,679	269,712	15.26	11
12	Dietician					12
13	Food Service Supervisor	1,871	1,981	36,284	18.32	13
14	Head Cook	6,548	7,196	59,656	8.29	14
15	Cook Helpers/Assistants	10,988	11,960	85,157	7.12	15
16	Dishwashers					16
17	Maintenance Workers	1,997	2,167	30,746	14.19	17
18	Housekeepers	19,289	20,595	149,506	7.26	18
19	Laundry	6,228	7,116	56,427	7.93	19
20	Administrator	2,041	2,198	65,525	29.81	20
21	Assistant Administrator	822	874	14,943	17.10	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,904	9,573	182,174	19.03	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	2,435	2,720	34,871	12.82	31
32	Other Health Care(specify)					32
33	Other(specify) <u>SECURITY</u>	5,680	6,164	49,925	8.10	33
34	TOTAL (lines 1 - 33)	174,024	188,324	\$ 2,532,409 *	\$ 13.45	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	\$ 8,914	1-3	35
36	Medical Director	O	23,700	9-3	36
37	Medical Records Consultant	N	2,326	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	2,016	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>		0	10-3	47
48	<u>M/C & PA CONSULTING</u>		69,107	10-3	48
49	TOTAL (lines 35 - 48)		\$ 116,863		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	Amount
AMY WALKO	ADMIN		\$ 65,525	Workers' Compensation Insurance	\$ 71,773	IDPH License Fee	\$	
TANYA EVERETT	ASST ADMIN		14,943	Unemployment Compensation Insurance	42,084	Advertising: Employee Recruitment		3,732
				FICA Taxes	191,203	Health Care Worker Background Check		352
				Employee Health Insurance	33,085	(Indicate # of checks performed <u>191</u>)		
				Employee Meals	13,907	Patient Background Checks	<u>159</u>	0
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC		675
				EMPLOYEE BENEFITS - OTHER	969	MARKETING/ADV/PROMO		4,365
				EMPLOYEE PHYSICAL EXAMS	2,321	LICENSES/DUES/SUBSCRIPTIONS		3,670
				PENSION/PROFIT SHARING PLANS	38,583	MGMT CO ALLOCATION		2,659
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC		(675)
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising		(4,365)
						Yellow page advertising	(0)
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 80,468	TOTAL (agree to Schedule V, line 22, col.8)	\$ 393,925	TOTAL (agree to Sch. V, line 20, col. 8)	\$	10,413
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		55,000					
							In-State Travel	
							TRAVEL & LODGING	319
							MGMT CO ALLOCATION	1,165
							(IL LODGING BETW FACIL & MGT CO)	
							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)			\$ 235,000	TOTAL		\$	TOTAL	\$ 1,484
C. Professional Services								
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
			\$			\$		
SEE SCHEDULE ATTACHED			240,278					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 240,278					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number **HILLCREST HEALTHCARE CENTER**# **0037572**Report Period Beginning: **01/01/2006**Ending: **12/31/2006****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. \$ 0 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department 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. \$ 13,907 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