

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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

I. IDPH Facility ID Number: 0001099

Facility Name: HILLCREST HOME

Address: 14688 ILLINOIS HIGHWAY 82 GENESEO 61254
 Number City Zip Code

County: HENRY

Telephone Number: (309) 944-2147 **Fax #** (309) 944-8417

HFS ID Number: 36-6001257001

Date of Initial License for Current Owners: 06/10/56

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: JAMES E TAYLOR **Telephone Number:** (309) 762-3626

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/01/05 to 11/30/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>MARY BERGREN</u>	
	(Title) <u>ADMINISTRATOR</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) <u>JAMES E. TAYLOR</u> <u>MEMBER</u>	
	(Firm Name & Address) <u>CARPENTIER, MITCHELL, GODDARD & CO, LLC</u> <u>4915 21ST AVENUE A, MOLINE, IL 61265</u>	
	(Telephone) <u>(309) 762-3626</u> Fax # <u>(309) 762-4465</u>	

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

Facility Name & ID Number HILLCREST HOME# 0001099 Report Period Beginning: 12/01/05 Ending: 11/30/06

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 05/16/05

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>106</u>	Skilled (SNF)	<u>106</u>	<u>38,690</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>106</u>	TOTALS	<u>106</u>	<u>38,690</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>688</u>	<u>1,042</u>	<u>35</u>	<u>1,765</u>	8
9	SNF/PED					9
10	ICF	<u>16,268</u>	<u>15,004</u>		<u>31,272</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>16,956</u>	<u>16,046</u>	<u>35</u>	<u>33,037</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.39%

D. How many bed-hold days during this year were paid by the Department?

79 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

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

G. Do pages 3 & 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 06/10/53

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified 11 and days of care provided 1,726Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 11/30/06 Fiscal Year: 11/30/06

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

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/05 Ending: 11/30/06

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	297,651	15,610	8,535	321,796		321,796		321,796		1
2	Food Purchase		153,253		153,253		153,253	(1,858)	151,395		2
3	Housekeeping	99,954	5,699	737	106,390		106,390		106,390		3
4	Laundry	97,171	10,871		108,042		108,042		108,042		4
5	Heat and Other Utilities			126,717	126,717		126,717	(3,232)	123,485		5
6	Maintenance	101,068	13,644	39,150	153,862		153,862		153,862		6
7	Other (specify):*										7
8	TOTAL General Services	595,844	199,077	175,139	970,060		970,060	(5,090)	964,970		8
	B. Health Care and Programs										
9	Medical Director			600	600		600		600		9
10	Nursing and Medical Records	1,512,819	125,598	72,016	1,710,433		1,710,433	(8,560)	1,701,873		10
10a	Therapy	100,050		128,457	228,507		228,507	(315,776)	(87,269)		10a
11	Activities	47,254	2,156	1,272	50,682		50,682	(144)	50,538		11
12	Social Services	57,407	32	1,800	59,239		59,239		59,239		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,717,530	127,786	204,145	2,049,461		2,049,461	(324,480)	1,724,981		16
	C. General Administration										
17	Administrative	63,113			63,113		63,113		63,113		17
18	Directors Fees										18
19	Professional Services			11,515	11,515		11,515		11,515		19
20	Dues, Fees, Subscriptions & Promotions			24,045	24,045		24,045	(9,248)	14,797		20
21	Clerical & General Office Expenses	123,842	7,115	49,364	180,321		180,321	(8,829)	171,492		21
22	Employee Benefits & Payroll Taxes			755,863	755,863		755,863	(1,776)	754,087		22
23	Inservice Training & Education			535	535		535		535		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			54,580	54,580		54,580		54,580		26
27	Other (specify):* LOSS ON ASSET DISPOSAL			234,596	234,596		234,596		234,596		27
28	TOTAL General Administration	186,955	7,115	1,130,498	1,324,568		1,324,568	(19,853)	1,304,715		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,500,329	333,978	1,509,782	4,344,089		4,344,089	(349,423)	3,994,666		29

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

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

Facility Name & ID Number HILLCREST HOME #0001099 Report Period Beginning: 12/01/05 Ending: 11/30/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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			220,330	220,330	220,330	(35,652)	184,678				30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			220,330	220,330	220,330	(35,652)	184,678				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			3,385	3,385	3,385	(807)	2,578				38
39	Ancillary Service Centers			243,076	243,076	243,076	(62,714)	180,362				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		5,869		5,869	5,869	(5,869)					41
42	Provider Participation Fee			58,035	58,035	58,035		58,035				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		5,869	304,496	310,365	310,365	(69,390)	240,975				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,500,329	339,847	2,034,608	4,874,784	4,874,784	(454,465)	4,420,319				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 HOME

0001099

Report Period Beginning: 12/01/05

Ending: 11/30/06

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	(1,858)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,232)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				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				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				17
18	Fines and Penalties				18
19	Entertainment	(1,776)	22		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(8,780)	21		24
25	Fund Raising, Advertising and Promotional	(9,248)	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	(429,571)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (454,465)		\$	30

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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (454,465)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

HILLCREST HOME

ID# 0001099

Report Period Beginning: 12/01/05

Ending: 11/30/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	MEDICARE REIMBURSEMENTS	\$ (62,714)	39	1
2	TELEPHONE CALLS CHARGED TO PATIENTS	(19)	21	2
3	TRANSPORTATION	(807)	38	3
4	OXYGEN REIMBURSEMENT	(8,560)	10	4
5	ACTIVITIES FEES	(144)	11	5
6	THERAPY REIMBURSEMENTS	(315,776)	10A	6
7	VENDING MACHINE	(5,869)	41	7
8	DEPRECIATION ADJUSTMENT	(35,652)	30	8
9	MISCELLANEOUS	(30)	21	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	(429,571)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number HILLCREST HOME

0001099

Report Period Beginning:

12/01/05

Ending:

11/30/06

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,858)	0	0	0	0	0	0	0	0	0	0	(1,858)	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	(3,232)	0	0	0	0	0	0	0	0	0	0	(3,232)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(5,090)	0	0	0	0	0	0	0	0	0	0	(5,090)	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	(8,560)	0	0	0	0	0	0	0	0	0	0	(8,560)	10
10a	Therapy	(315,776)	0	0	0	0	0	0	0	0	0	0	(315,776)	10a
11	Activities	(144)	0	0	0	0	0	0	0	0	0	0	(144)	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	(324,480)	0	0	0	0	0	0	0	0	0	0	(324,480)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(9,248)	0	0	0	0	0	0	0	0	0	0	(9,248)	20
21	Clerical & General Office Expenses	(8,829)	0	0	0	0	0	0	0	0	0	0	(8,829)	21
22	Employee Benefits & Payroll Taxes	(1,776)	0	0	0	0	0	0	0	0	0	0	(1,776)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(19,853)	0	0	0	0	0	0	0	0	0	0	(19,853)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(349,423)	0	0	0	0	0	0	0	0	0	0	(349,423)	29

STATE OF ILLINOIS

Facility Name & ID Number HILLCREST HOME

0001099

Report Period Beginning:

12/01/05 Ending:

Summary B

11/30/06

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(35,652)	0	0	0	0	0	0	0	0	0	0	(35,652)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(35,652)	0	(35,652)	37									
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	(807)	0	0	0	0	0	0	0	0	0	0	(807)	38
39	Ancillary Service Centers	(62,714)	0	0	0	0	0	0	0	0	0	0	(62,714)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	(5,869)	0	0	0	0	0	0	0	0	0	0	(5,869)	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	(69,390)	0	(69,390)	44									
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(454,465)	0	(454,465)	45									

Facility Name & ID Number HILLCREST HOME

0001099

Report Period Beginning:

12/01/05

Ending:

11/30/06

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
HENRY COUNTY	100	NONE				

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	
1	V		\$			\$	\$
2	V						
3	V						
4	V						
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$			\$	\$ *

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

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/05 Ending: 11/30/06

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									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number HILLCREST HOME

0001099

Report Period Beginning: 12/01/05

Ending: 11/30/06

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6										6										
7										7										
8										8										
9	TOTAL Facility Related					\$	\$		\$	9										
B. Non-Facility Related*																				
10										10										
11										11										
12										12										
13										13										
14	TOTAL Non-Facility Related					\$	\$		\$	14										
15	TOTALS (line 9+line14)					\$	\$		\$	15										

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

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

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

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

B. Real Estate Taxes

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.		\$	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.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	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.		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2001	<u>N/A</u>	<u>8</u>
	2002	<u>N/A</u>	<u>9</u>
	2003	<u>N/A</u>	<u>10</u>
	2004	<u>N/A</u>	<u>11</u>
	2005	<u>N/A</u>	<u>12</u>
	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

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:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME HILLCREST HOME COUNTY HENRY

FACILITY IDPH LICENSE NUMBER 0001099

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (____) _____ FAX #: (____) _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(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. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

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 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number HILLCREST HOME

0001099 Report Period Beginning:

12/01/05 Ending:

11/30/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 67,394 B. General Construction Type: Exterior BRICK Frame _____ 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).

NONE

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>	<u>6 ACRES</u>	<u>VARIOUS</u>	\$ <u>1,000</u>	1
2					2
3	TOTALS	#VALUE!		\$ 1,000	3

Facility Name & ID Number HILLCREST HOME

0001099

Report Period Beginning:

12/01/05

Ending:

11/30/06

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	84		1971	1971	\$ 220,795	\$ 4,416	50	\$ 4,416		\$ 151,356	4
5	22		1976	1976	1,064,182	21,283	50	21,283		654,975	5
6											6
7											7
8											8
	Improvement Type**										
9	GENERAL			1977	52,950	1,059	50	1,059		31,770	9
10	GENERAL			1979	6,552		3			6,552	10
11	GENERAL			1980	14,609	293	50	293		7,743	11
12	GENERAL			1981	61,074	1,221	50	1,221		31,146	12
13	GENERAL			1982	6,189		3			6,189	13
14	GENERAL			1983	79,248	1,317	.10-50	1,317		49,375	14
15	GENERAL			1984	46,106	848	.10-50	848		22,794	15
16	GENERAL			1985	76,531	913	.20-30	913		41,708	16
17	GENERAL			1986	76,930	518	.20-30	518		52,588	17
18	GENERAL			1987	120,391	3,544	30	3,544		79,539	18
19	GENERAL			1988	70,622	2,006	.12-40	2,006		40,153	19
20	GENERAL			1989	209,235	5,214	.20-40	5,214		126,733	20
21	GENERAL			1990	810,969	27,032	30	27,032		599,881	21
22	GENERAL			1991	336,390	11,213	30	11,213		244,212	22
23	GENERAL			1992	121,611	4,597	.5-20	4,597		87,715	23
24	GENERAL			1993	57,379	1,582	.5-20	1,582		42,409	24
25	GENERAL			1994	106,380	78	.10-20	78		69,459	25
26	GENERAL			1995	106,336	3,868	.10-40	3,868		55,805	26
27	RECOAT ROOF			1996	2,495	125	20	125		1,279	27
28	LIGHT FIXTURES			1996	1,855	92	10	92		1,855	28
29	HAND RAILS			1996	1,669		5			1,669	29
30	TUCK POINTING			1996	8,272	413	20	413		4,377	30
31	GARAGE			1997	5,708	143	40	143		1,339	31
32	AIR CONDITIONING			1997	35,751	1,788	20	1,788		16,535	32
33	COOLER			1997	18,258	913	20	913		8,977	33
34	BUILDING LIGHTS			1997	1,517		5			1,517	34
35	ROOF			1997	4,620	154	30	154		1,463	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number HILLCREST HOME

0001099

Report Period Beginning:

12/01/05

Ending:

11/30/06

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	PUMP HOUSE REPAIRS	1997	\$ 800	\$ 40	20	\$ 40	\$	\$ 393	37
38	EXPAND LAGOON SYSTEM	1998	370,488	12,350	30	12,350		120,409	38
39	BOILER REPAIRS	1998	1,649	165	10	165		1,319	39
40	WATER HEATER	1998	3,550	355	10	355		3,136	40
41	ROOF	1998	5,477	274	20	274		2,328	41
42	GUTTERS	1998	5,767	288	20	288		2,571	42
43	EXPAND LAGOON SYSTEM	1999	46,155	2,308	20	2,308		16,709	43
44	BOILER REPAIRS	1999	23,138	2,314	10	2,314		16,197	44
45	HEATING MOTOR	1999	3,000	300	10	300		2,300	45
46	PARKING LOT LIGHTS	1999	1,284	128	10	128		1,027	46
47	CARPET	2000	2,626	263	10	263		1,641	47
48	WATER LINE REPAIR	2000	620	62	10	62		388	48
49	REFURBISH WASHERS	2000	3,168	316	10	316		2,085	49
50	A/C REPAIR	2000	6,781	679	10	679		4,408	50
51	WATER HEATER REPAIR	2000	5,425	543	10	543		3,662	51
52	REMODELING	2001	8,630		20			2,014	52
53	CONCRETE WORK	2001	1,512	152	10	152		769	53
54	GAS LINE REPAIR	2001	21,529	2,152	10	2,152		11,661	54
55	A/C REFURBISH	2001	4,169	417	10	417		2,363	55
56	HEAT REFURBISH	2001	7,859	785	10	785		4,322	56
57	WATER HEATER	2001	6,488	648	10	648		3,622	57
58	WATER HEATER	2001	5,551	555	10	555		3,238	58
59	A/C REFURBISH	2002	8,661	866	10	866		3,897	59
60	HEATER REFURBISH	2002	6,994	699	10	699		3,147	60
61	WATER HEATER	2002	2,562	257	10	257		1,068	61
62	SATELITTE	2002	14,037	1,404	10	1,404		5,966	62
63	IRON PUMP	2002	1,386	139	10	139		693	63
64	SHOWER ROOM REPAIR	2002	3,096		10			1,213	64
65	KITCHENETTE ADDITIONS	2002	2,270		10			889	65
66	KITCHENETTE ADDITIONS	2002	4,021	402	10	402		1,809	66
67	GARAGE PAINTING	2002	1,670	167	10	167		724	67
68	HOUSEKEEPING OFFICE ADDITIONS	2002	2,161	216	10	216		1,026	68
69	PRIVATE ROOMS REPAIR	2002	7,441		10			2,605	69
70	TOTAL (lines 4 thru 69)		\$ 4,314,589	\$ 123,874		\$ 123,874	\$	\$ 2,670,712	70

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

Facility Name & ID Number HILLCREST HOME

0001099

Report Period Beginning:

12/01/05

Ending:

11/30/06

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	
1	Totals from Page 12A, Carried Forward		\$ 4,314,589	\$ 123,874		\$ 123,874	\$	\$ 2,670,712	1
2	WHIRLPOOL SYSTEM	2003	10,311	1,031	10	1,031		3,781	2
3	ELEVATOR REPAIR	2003	3,300	330	10	330		1,155	3
4	SATELLITE	2003	500	50	10	50		171	4
5	BUILDING SHUTTERS	2003	872	87	10	87		283	5
6	BLACKTOP DRIVEWAY	2003	9,887	989	10	989		3,296	6
7	PERGOLA ENTRYWAY	2003	3,433	343	10	343		1,173	7
8	REFURBISH RESIDENTS ROOMS	2003	15,698		10			3,401	8
9	A/C & HEAT REPAIR	2003	1,000	100	10	100		333	9
10	REFURBISH HEAT & A/C	2003	17,570	1,757	10	1,757		6,296	10
11	REMODEL SMOKING ROOMS	2003	9,131		10			2,511	11
12	PARKER TUB	2004	500	50	10	50		150	12
13	BRICKS FOR SIGN	2004	675	67	10	67		202	13
14	LANDSCAPING	2004	966	97	10	97		242	14
15	3D LETTERS FOR SIGN	2004	793	80	10	80		192	15
16	FIRE & SMOKE DAMPERS	2004	3,717	371	10	371		898	16
17	WELL PUMP	2004	3,043	304	10	304		735	17
18	TRANSFER SWITCH	2004	514	51	10	51		120	18
19	SE SITTING ROOM	2004	2,634	264	10	264		593	19
20	KITCHEN LIGHTS	2004	2,209	221	10	221		644	20
21	RESIDENTIAL BATHROOMS	2004	10,300	1,030	10	1,030		2,918	21
22	SMOKE DAMPERS TEST STATION	2004	1,127	113	10	113		310	22
23	PAINTING	2004	4,522	453	10	453		1,018	23
24	SCREENHOUSE	2004	1,682	168	10	168		378	24
25	LAUNDRY PROJECT	2004	3,455	345	10	345		921	25
26	BOILER REPLACEMENT	2004	17,001	1,700	10	1,700		4,675	26
27	NW MECHANICAL ROOM A/C	2004	4,516	452	10	452		1,054	27
28	SOUTH LINEN ROOM RENOVATION	2004	1,968	197	10	197		492	28
29	EXIT LIGHTS	2004	2,023	202	10	202		573	29
30	TRANSFER SWITCH	2004	3,946	395	10	395		921	30
31	ROOF REPAIR	2004	2,394	239	10	239		638	31
32	NORTHWEST WORK	2005	102	10	10	10		17	32
33	CEMETERY FENCE	2005	2,784	278	10	278		394	33
34	TOTAL (lines 1 thru 33)		\$ 4,457,162	\$ 135,648		\$ 135,648	\$	\$ 2,711,197	34

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

Facility Name & ID Number HILLCREST HOME

0001099

Report Period Beginning:

12/01/05

Ending:

11/30/06

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	
1	Totals from Page 12B, Carried Forward		\$ 4,457,162	\$ 135,648		\$ 135,648	\$	\$ 2,711,197	1
2	WELL PROJECT	2005	17,949	1,794	10	1,794		2,541	2
3	CEMETERY FENCE	2005	2,784	278	10	278		371	3
4	BEAUTY SHOP	2005	927	92	10	92		94	4
5	BRICK	2005	150	15	10	15		19	5
6	CEMENT PADS	2005	3,550	355	10	355		355	6
7	NEW LOUNGE HOURS SIGN	2005	3,142	314	10	314		314	7
8	BEAUTY SHOP HOURS SIGN	2005	2,650	265	10	265		265	8
9	NW NURSE STN HOURS SIGN	2005	9,030	903	10	903		903	9
10	BASEMENT OFFICE HOURS SIGN	2005	2,610	261	10	261		261	10
11	RESIDENT ROOM HOURS SIGN	2005	1,704	170	10	170		170	11
12	EAST SHOWER HOURS SIGN	2005	530	53	10	53		53	12
13	HEATERS	2005	7,172	717	10	717		717	13
14	DISHWASHER	2005	2,180	218	10	218		218	14
15	COOLERS	2005	2,597	260	10	260		260	15
16	BREAKROOM	2005	3,267	326	10	326		326	16
17	ROOF REPAIRS	2005	1,642	165	10	165		165	17
18	NORTHWEST WORK	2005	2,319	232	10	232		232	18
19	WATER HEATER	2005	4,799	480	10	480		480	19
20	SHOP PROJECT	2005	3,965	396	10	396		396	20
21	NW NURSE STATION	2005	851	85	10	85		85	21
22	BUILDING REPAIR - ASBESTOS STUDY	2005	5,450	545	10	545		727	22
23	AMBULANCE ENTRANCE	2005	4,770	437	10	437		437	23
24	DRIVEWAY	2006	518	30	10	30		30	24
25	SOUTHWEST ENTRANCE	2006	3,050	25	10	25		25	25
26	CEMETERY LANDSCAPING	2006	1,395	58	10	58		58	26
27	RESIDENT ROOMS	2006	18,233		10				27
28	ICE MACHINE ROOM	2006	2,269	170	10	170		170	28
29	SHOWER ROOMS	2006	5,205	347	10	347		347	29
30	DOOR ALARM	2006	73,958	2,465	10	2,465		2,465	30
31	REFURBISH SATELLITE DISH	2006	3,377	57	10	57		57	31
32	KITCHEN IMPROVEMENT	2006	2,544	148	10	148		148	32
33	ROOF REPAIRS	2006	25,154	210	10	210		210	33
34	TOTAL (lines 1 thru 33)		\$ 4,676,903	\$ 147,519		\$ 147,519	\$	\$ 2,724,096	34

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

Facility Name & ID Number HILLCREST HOME

0001099

Report Period Beginning:

12/01/05

Ending:

11/30/06

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	
1	Totals from Page 12C, Carried Forward		\$ 4,676,903	\$ 147,519		\$ 147,519	\$	\$ 2,724,096	1
2	REFURBISH AIR CONDITIONER	2006	7,406	309	10	309		309	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
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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	TOTAL (lines 1 thru 33)		\$ 4,684,309	\$ 147,828		\$ 147,828	\$	\$ 2,724,405	34

**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	\$ 316,848	\$ 29,370	\$ 29,370	\$		\$ 182,041	71
72	Current Year Purchases	34,540	1,422	1,422			1,422	72
73	Fully Depreciated Assets	723,456					723,456	73
74								74
75	TOTALS	\$ 1,074,844	\$ 30,792	\$ 30,792	\$		\$ 906,919	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	PATIENT TRANSPORT	1996 CHEVY VAN	1996	\$ 34,005	\$	\$	\$	4	\$ 34,005	76
77	PATIENT TRANSPORT	2001 DODGE CARAVAN	2003	25,000	5,000	5,000		5	15,417	77
78	PATIENT TRANSPORT	2001 DODGE VAN	2005	10,575	1,058	1,058		10	1,939	78
79										79
80	TOTALS			\$ 69,580	\$ 6,058	\$ 6,058	\$		\$ 51,361	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)		\$ 5,829,733	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 184,678	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 184,678	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 3,682,685	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	91 LUMINA/1991	\$ 11,952	\$	\$ 11,952	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 11,952	\$	\$ 11,952	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.

Facility Name & ID Number HILLCREST HOME

0001099

Report Period Beginning: 12/01/05

Ending: 11/30/06

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

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>
--	---	--

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		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	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 HOME# 0001099Report Period Beginning: 12/01/05

Ending:

11/30/06**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 11/30/06

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,502,347	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 9,000)	463,551		3
4	Supply Inventory (priced at)	27,102		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>SEE ATTACHED</u>	8,581		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,001,581	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,000		13
14	Buildings, at Historical Cost	5,075,042		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,152,906		16
17	Accumulated Depreciation (book methods)	(3,949,958)		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)	\$ 2,278,990	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,280,571	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 132,124	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	147,709		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 279,833	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 279,833	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,000,738	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,280,571	\$	48

*(See instructions.)

HILLCREST HOME
ID#0001099

YEAR ENDED 11/30/06

SCHEDULE XV - BALANCE SHEET

LINE 9 - OTHER CURRENT ASSETS

	AMOUNT
PREPAID EXPENSE	745
ACCRUED INTEREST	<u>7,836</u>
TOTAL	<u><u>8,581</u></u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,142,234	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,142,234	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(678,458)	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)	\$ (678,458)	17
	B. Transfers (Itemize):		
18	FICA REIMBURSEMENT	185,811	18
19	IMRF REIMBURSEMENT	191,085	19
20	INSURANCE REIMBURSEMENT	141,256	20
21	OTHER REIMBURSEMENT	18,810	21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 536,962	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,000,738	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number HILLCREST HOME# 0001099Report Period Beginning: 12/01/05Ending: 11/30/06**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	\$ 3,606,733	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,606,733	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	315,776	6
7	Oxygen	8,560	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 324,336	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	1,858	14
15	Telephone, Television and Radio	19	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)	\$ 1,877	23
D. Non-Operating Revenue			
24	Contributions	99,360	24
25	Interest and Other Investment Income***	53,801	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 153,161	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	SEE ATTACHED SCHEDULE	110,219	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 110,219	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,196,326	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	970,060	31
32	Health Care	2,049,461	32
33	General Administration	1,324,568	33
B. Capital Expense			
34	Ownership	220,330	34
C. Ancillary Expense			
35	Special Cost Centers	252,330	35
36	Provider Participation Fee	58,035	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,874,784	40
41	Income before Income Taxes (line 30 minus line 40)**	(678,458)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (678,458)	43

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

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

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

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

HILLCREST HOME
ID #0001099

YEAR ENDED 11/30/06

SCHEDULE XVII - INCOME STATEMENT

E. OTHER REVENUE

	AMOUNT
MEDICARE PHARMACY PART A	42,122
MEDICARE LAB	8,535
MEDICARE RADIOLOGY	5,591
MEDICARE MISCELLANEOUS PART B	2,117
MEDICARE ME SUPPLIES PART A	4,349
VENDING MACHINE	10,114
NURSING SUPPLIES	25,310
TRANSPORTATION	807
ACTIVITIES FEES	144
MISCELLANEOUS	<u>11,130</u>
TOTAL	<u><u>110,219</u></u>

Facility Name & ID Number **HILLCREST HOME**

0001099

Report Period Beginning:

12/01/05

Ending:

11/30/06

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,701	2,080	\$ 60,027	\$ 28.86	1
2	Assistant Director of Nursing	1,740	2,080	55,661	26.76	2
3	Registered Nurses	8,855	10,351	222,197	21.47	3
4	Licensed Practical Nurses	16,669	19,590	327,509	16.72	4
5	CNAs & Orderlies	68,718	78,558	812,547	10.34	5
6	CNA Trainees	1,014	1,193	10,225	8.57	6
7	Licensed Therapist	625	625	26,473	42.36	7
8	Rehab/Therapy Aides	1,123	1,187	20,372	17.16	8
9	Activity Director					9
10	Activity Assistants	4,245	5,038	47,254	9.38	10
11	Social Service Workers	3,400	4,077	57,407	14.08	11
12	Dietician					12
13	Food Service Supervisor	1,720	2,080	41,986	20.19	13
14	Head Cook	3,483	4,154	42,012	10.11	14
15	Cook Helpers/Assistants	21,705	24,464	213,653	8.73	15
16	Dishwashers					16
17	Maintenance Workers	8,591	10,367	101,068	9.75	17
18	Housekeepers	8,009	9,626	99,954	10.38	18
19	Laundry	8,574	10,080	97,171	9.64	19
20	Administrator	1,811	2,080	63,113	30.34	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,368	8,865	123,842	13.97	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,730	2,080	25,134	12.08	31
32	Other Health Care CARE PLAN COO	1,988	2,297	52,724	22.95	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	173,069	200,872	\$ 2,500,329 *	\$ 12.45	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	125	\$ 6,749		35
36	Medical Director	6	600		36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	600		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	16	1,365		45
46	Other(specify)				46
47	WASTE TREATMENT	48	3,000		47
48	WATER TREATMENT	48	2,970		48
49	TOTAL (lines 35 - 48)	291	\$ 15,284		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	65	\$ 2,739		50
51	Licensed Practical Nurses	1,946	61,911		51
52	Certified Nurse Assistants/Aides	8	159		52
53	TOTAL (lines 50 - 52)	2,019	\$ 64,809		53

Facility Name & ID Number **HILLCREST HOME**

0001099

Report Period Beginning: **12/01/05**

Ending: **11/30/06**

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	
MARY BERGREN		0	\$ 63,113	Workers' Compensation Insurance	\$ 86,676	IDPH License Fee	\$	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	7,710	
				FICA Taxes	185,811	Health Care Worker Background Check		
				Employee Health Insurance	290,285	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	187 1,870	
				Illinois Municipal Retirement Fund (IMRF)*	191,085	PUBLIC RELATIONS	9,248	
				PHYSICALS	100	DUES & SUBSCRIPTIONS	5,217	
				HEPATITIS VACCINE	130			
				EMPLOYEE RECOGNITION	1,776			
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 63,113			Less: Public Relations Expense	(1,053)	
(List each licensed administrator separately.)						Non-allowable advertising	(8,195)	
						Yellow page advertising	()	
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
	\$			LESS: ENTERTAINMENT		(1,776)	Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)		754,087	Seminar Expense	
(Attach a copy of any management service agreement)								
C. Professional Services				TOTAL			TOTAL (agree to Sch. V, line 20, col. 8)	
Vendor/Payee	Type	Amount		\$			\$	
CMG & COMPANY	COST REPORT/AUDIT	\$ 2,400					14,797	
STATE'S ATTORNEY	LEGAL FEES	615						
FR&R	MEDICARE COST REPORT	3,500						
SELECT REHABILITATION	CONTRACT BUY OUT	5,000						
TOTAL (agree to Schedule V, line 19, column 3)			\$ 11,515				Entertainment Expense ()	
(If total legal fees exceed \$5,000, attach copy of invoices.)							TOTAL (agree to Sch. V, line 24, col. 8)	

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. COUNTY NURSING HOME ASSN - \$920
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (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
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 34,633 Line 10
- (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. N/A
- (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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 58,035
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. \$ 0 Has any meal income been offset against related costs? YES Indicate the amount. \$ 1,858
- (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. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 0%
- d. Have vehicle usage logs been maintained? YES
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- 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? YES
Firm Name: CARPENTIER, MITCHELL, GODDARD & CO The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NO If no, please explain. AUDIT APPROVED IN MAY
- (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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.