

Facility Name & ID Number HILLSIDE REHABILITATION & CARE CENTER

0047100 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	<u>58</u>	Skilled (SNF)	<u>58</u>	<u>21,170</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>21</u>	Intermediate (ICF)	<u>21</u>	<u>7,665</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>79</u>	TOTALS	<u>79</u>	<u>28,835</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>5</u>	<u>95</u>	<u>2,448</u>	<u>2,548</u>	8
9	SNF/PED					9
10	ICF	<u>11,099</u>	<u>10,110</u>		<u>21,209</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>11,104</u>	<u>10,205</u>	<u>2,448</u>	<u>23,757</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.39%

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

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

NONE

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

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

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

I. On what date did you start providing long term care at this location?
Date started 04/01/05

J. Was the facility purchased or leased after January 1, 1978?
YES Date 04/01/05 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 79 and days of care provided 2,448

Medicare Intermediary ADMINISTAR FEDERAL

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 **HILLSIDE REHABILITATION & CARE CI** # **0047100** 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	128,894	11,286	8,168	148,348		148,348	0	148,348		1
2	Food Purchase		89,382		89,382	0	89,382	(109)	89,273		2
3	Housekeeping	87,843	8,813	0	96,656		96,656	0	96,656		3
4	Laundry	22,218	7,863	29,699	59,780	0	59,780	0	59,780		4
5	Heat and Other Utilities			59,627	59,627		59,627	1,021	60,648		5
6	Maintenance	25,624	10,295	16,690	52,609		52,609	5,496	58,105		6
7	Other (specify):*			8,738	8,738		8,738	0	8,738		7
8	TOTAL General Services	264,579	127,639	122,922	515,140	0	515,140	6,408	521,548		8
	B. Health Care and Programs										
9	Medical Director	0		10,200	10,200		10,200	0	10,200		9
10	Nursing and Medical Records	1,238,623	100,293	13,231	1,352,147		1,352,147	0	1,352,147		10
10a	Therapy	28,347	779	0	29,126		29,126	0	29,126		10a
11	Activities	38,719	3,585	120	42,424		42,424	0	42,424		11
12	Social Services	8,323		1,149	9,472		9,472	0	9,472		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			58	58		58	0	58		14
15	Other (specify):*				0		0	0	0		15
16	TOTAL Health Care and Programs	1,314,012	104,657	24,758	1,443,427	0	1,443,427	0	1,443,427		16
	C. General Administration										
17	Administrative	82,472		222,690	305,162		305,162	(156,842)	148,320		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			46,499	46,499		46,499	(6,367)	40,132		19
20	Dues, Fees, Subscriptions & Promotions			28,961	28,961		28,961	(10,666)	18,295		20
21	Clerical & General Office Expenses	95,173	11,291	77,294	183,758		183,758	(67,501)	116,257		21
22	Employee Benefits & Payroll Taxes			267,122	267,122	0	267,122	0	267,122		22
23	Inservice Training & Education			9,198	9,198		9,198	0	9,198		23
24	Travel and Seminar			2,993	2,993		2,993	70	3,063		24
25	Other Admin. Staff Transportation			0	0		0	1,317	1,317		25
26	Insurance-Prop.Liab.Malpractice			53,691	53,691		53,691	1,955	55,646		26
27	Other (specify):*			27,041	27,041		27,041	(11,110)	15,931		27
28	TOTAL General Administration	177,645	11,291	735,489	924,425	0	924,425	(249,144)	675,281		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,756,236	243,587	883,169	2,882,992	0	2,882,992	(242,736)	2,640,256		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	8,168
	REPAIRS & MAINTENANCE	0
		0
		8,168
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	34
	CONTRACTED LAUNDRY SERVICES	29,665
		29,699
5	HEAT & OTHER UTILITIES	
	GAS HEAT	1,207
	ELECTRICITY	44,603
	WATER	8,022
	CABLE TV - LOBBY	5,795
		0
		59,627
6	MAINTENANCE	
	GROUNDS MAINTENANCE	3,564
	PAINTING & DECORATING	52
	BUILDING REPAIRS	2,893
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	2,754
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	132
	EXTERMINATING SERVICE	835
	FIRE SERVICE	6,460
		0
		0
		0
		0
		16,690
7	OTHER	
	SCAVENGER	8,738
	SECURITY SERVICE	0
		0
		0
		8,738
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	10,200
		10,200

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	9,273
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,600
	PHARMACY CONSULTANT XVIII B 39-2	2,358
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		13,231
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	
	OCCUPATIONAL THERAPY SERVICES	
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
	PROGRAM CONSULTANT	120
		120
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	1,149
	SOCIAL WORKER XVIII B 45-2	0
		0
		1,149
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	58
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	222,690
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	8,028
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	38,471
		0
		46,499
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	5,580
	EMPLOYEE WANT ADS XIX F	4,917
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	8,277
	LICENSES & PERMITS XIX F	2,613
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	5,350
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,056
	PATIENT BACKGROUND CHECKS XIX F	1,168
		28,961
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	4,829
	EQUIPMENT REPAIR & MAINTENANCE	96
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	545
	HOME OFFICE EXPENSE	60,000
	THEFT & DAMAGE LOSS	0
	TELEPHONE	11,824
	MESSENGER SERVICE	0
		0
		77,294

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	133,130
	UNEMPLOYMENT COMPENSATION XIX D	41,146
	WORKERS COMPENSATION INSURANC XIX D	59,410
	HOSPITALIZATION INSURANCE XIX D	27,564
	EMPLOYEE BENEFITS - OTHER XIX D	4,810
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	1,062
	CHICAGO HEAD TAX XIX D	0
		0
		267,122
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	9,198
		9,198
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	2,993
		2,993
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	0
		0
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	53,691
		53,691
27	OTHER	
	BAD DEBTS VI 24	27,041
		27,041

GRAND TOTAL COLUMN 3 OTHER

883,169

HILLSIDE REHABILITATION & CARE CENTER
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2006

TOTAL FOOD PURCHASE	89,382	PATIENT MEALS	71271
LESS SALES TAX	(109)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	89,273	TOTAL MEALS/YEAR	71271
TOTAL PATIENT CENSUS	23,757	NET FOOD	89273
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	71271

TOTAL PATIENT MEALS	71271	COST PER MEAL	1.25
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY			-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number

HILLSIDE REHABILITATION & CARE CENTER

#0047100

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			5,233	5,233		5,233	(2,544)	2,689			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			28,542	28,542		28,542	2,198	30,740			32
33	Real Estate Taxes			78,512	78,512		78,512	534	79,046			33
34	Rent-Facility & Grounds			346,020	346,020		346,020	0	346,020			34
35	Rent-Equipment & Vehicles			12,337	12,337		12,337	0	12,337			35
36	Other (specify):* amort computer software			7,307	7,307		7,307	0	7,307			36
37	TOTAL Ownership			477,951	477,951	0	477,951	188	478,139			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		74,950	249,117	324,067		324,067	0	324,067			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			43,253	43,253		43,253	0	43,253			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	74,950	292,370	367,320	0	367,320	0	367,320			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,756,236	318,537	1,653,490	3,728,263	0	3,728,263	(242,548)	3,485,715			45

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

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(3,377)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(109)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(545)	21		18
19	Entertainment	0	20		19
20	Contributions	0	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(27,041)	27		24
25	Fund Raising, Advertising and Promotional	(5,580)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(5,350)	20		28
29	Other-Attach Schedule	(35,697)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (77,699)		\$ 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)	(164,849)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (164,849)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (242,548)		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

STATE OF ILLINOIS
HILLSIDE REHABILITATION & CARE CENTER

ID# 0047100

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 0	6	1
2	MARKETING SALARIES	(21,406)	21	2
3	BANK CHARGES	(4,829)	21	3
4	HEALTHCARE HORIZONS	(9,000)	19	4
5	MARKETING TRAVEL	(462)	24	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	(35,697)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number HILLSIDE REHABILITATION & CARE CENTER# 0047100

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	(109)	0	0	0	0	0	0	0	0	0	0	(109)	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	1,021	0	0	0	0	0	0	0	0	0	1,021	5
6	Maintenance	0	5,496	0	0	0	0	0	0	0	0	0	5,496	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(109)	6,517	0	6,408	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	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	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	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(156,842)	0	0	0	0	0	0	0	0	0	(156,842)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(9,000)	2,633	0	0	0	0	0	0	0	0	0	(6,367)	19
20	Fees, Subscriptions & Promotions	(10,930)	264	0	0	0	0	0	0	0	0	0	(10,666)	20
21	Clerical & General Office Expenses	(26,780)	(40,721)	0	0	0	0	0	0	0	0	0	(67,501)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(462)	532	0	0	0	0	0	0	0	0	0	70	24
25	Other Admin. Staff Transportation	0	1,317	0	0	0	0	0	0	0	0	0	1,317	25
26	Insurance-Prop.Liab.Malpractice	0	1,955	0	0	0	0	0	0	0	0	0	1,955	26
27	Other (specify):*	(27,041)	15,931	0	0	0	0	0	0	0	0	0	(11,110)	27
28	TOTAL General Administration	(74,213)	(174,931)	0	(249,144)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(74,322)	(168,414)	0	(242,736)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number HILLSIDE REHABILITATION & CARE CENTER # 0047100 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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(3,377)	0	833	0	0	0	0	0	0	0	0	(2,544)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	2,198	0	0	0	0	0	0	0	0	2,198	32
33	Real Estate Taxes	0	0	534	0	0	0	0	0	0	0	0	534	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	(3,377)	0	3,565	0	188	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	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(77,699)	(168,414)	3,565	0	(242,548)	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
WILLIAM IRVINE	50			HI CARE MANAGEMENT	SPRINGFIELD	MANAGEMENT
ROBERT HEDGES	50	SEE ATTACHED		H.I. PROPERTIES	SPRINGFIELD	REAL ESTATE

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	\$ 222,690				\$ (222,690)	1
2	V	21 HOME OFFICE EXPENSE	60,000				(60,000)	2
3	V	5 UTILITIES				1,021	1,021	3
4	V	6 MAINTENANCE				5,496	5,496	4
5	V	17 ADMINISTRATIVE				65,848	65,848	5
6	V	19 PROFESSIONAL FEES				2,633	2,633	6
7	V	20 DUES & SUBSCRIPTIONS				264	264	7
8	V	21 OFFICE EXPENSE				19,279	19,279	8
9	V	24 TRAVEL & SEMINARS				532	532	9
10	V	25 TRANSPORTATION				1,317	1,317	10
11	V	26 INSURANCE				1,955	1,955	11
12	V	27 PAYROLL TAXES & GRP INS				15,931	15,931	12
13	V							13
14	Total		\$ 282,690			\$ 114,276	\$ * (168,414)	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	30 DEPRECIATION	\$	H & I PROPERTIES (HOME OFFICE)		\$ 833	\$ 833	15
16	V	32 INTEREST				2,198	2,198	16
17	V	33 REAL ESTATE TAXES				534	534	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 3,565	\$ * 3,565	39

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

Facility Name & ID Number **HILLSIDE REHABILITATION & CARE C** # **0047100** 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	ROBERT HEDGES	PRESIDENT	OFFICE MGMT.	50.00				SALARY	\$ 21,842	17-7	1
2	TOTAL ALLOWABLE SALARY RECEIVED FROM HI CARE \$170,000										2
3											3
4	WILLIAM IRVINE	VICE PRESIDENT	OFFICE MGMT.	50.00				SALARY	21,842	17-7	4
5	TOTAL ALLOWABLE SALARY RECEIVED FROM HI CARE \$170,000										5
6											6
7	MARTHA IRVINE	BOOKKEEPING						SALARY	1,107	21-7	7
8	TOTAL SALARY RECEIVED FROM HI CARE \$8,615										8
9											9
10	DEREK HEDGES	SPECIAL PROJECTS MNGR						SALARY	3,469	17-7	10
11	TOTAL SALARY RECEIVED FROM HI CARE \$27,000										11
12											12
13								TOTAL	\$ 48,260		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 HILLSIDE REHABILITATION & CARE CENTER # 0047100 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 HI CARE MANAGEMENT
 Street Address 1625 SOUTH 6TH STREET
 City / State / Zip Code SPRINGFIELD, IL. 62703
 Phone Number (217)528-0044
 Fax Number (217)528-0412

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	5	UTILITIES	PER RESIDENT DAY	184,904	7	\$ 7,946	23,757	\$ 1,021	1	
2	6	MAINTENANCE	PER RESIDENT DAY	184,904	7	42,775	36,113	23,757	5,496	2
3	17	OFFICER SALARY	PER RESIDENT DAY	184,904	7	340,000	340,000	23,757	43,684	3
4	17	DIRECTOR OF OPERATIONS	PER RESIDENT DAY	184,904	7	68,050	68,050	23,757	8,743	4
5	17	DIRECTOR OF FINANCE	PER RESIDENT DAY	184,904	7	77,460	77,460	23,757	9,952	5
6	17	SPECIAL PROJECTS MNGR	PER RESIDENT DAY	184,904	7	27,000	27,000	23,757	3,469	6
7	19	PROFESSIONAL FEES	PER RESIDENT DAY	184,904	7	20,492		23,757	2,633	7
8	20	DUES & SUBSCRIPTIONS	PER RESIDENT DAY	184,904	7	2,057		23,757	264	8
9	21	OFFICE EXPENSE	PER RESIDENT DAY	184,904	7	150,049	112,536	23,757	19,279	9
10	24	TRAVEL & SEMINARS	PER RESIDENT DAY	184,904	7	4,140		23,757	532	10
11	25	TRANSPORTATION	PER RESIDENT DAY	184,904	7	10,252		23,757	1,317	11
12	26	INSURANCE	PER RESIDENT DAY	184,904	7	15,218		23,757	1,955	12
13	27	PAYROLL TAXES & GRP INS	PER RESIDENT DAY	184,904	7	123,996		23,757	15,931	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					\$ 889,435	\$ 661,159	\$ 114,276		25

Facility Name & ID Number HILLSIDE REHABILITATION & CARE CENTER # 0047100 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

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

Name of Related Organization H & I PROPERTIES - HOME OFFICE
 Street Address 1625 S SIXTH STREET
 City / State / Zip Code SPRINGFIELD, IL. 62703
 Phone Number (217)528-0044
 Fax Number (217)528-0412

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	30	DEPRECIATION	639	7	\$ 6,741	\$ 0	79	\$ 833	1
2	32	INTEREST	639	7	17,780	0	79	2,198	2
3	33	REAL ESTATE	639	7	4,317	0	79	534	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				\$ 28,838	\$		\$ 3,565	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																				
2																				
3																				
4																				
5																				
Working Capital																				
6	COLE TAYLOR BANK	X	WORKING CAPITAL	INTEREST	11/5/05	500,000	318,743	REVOLV	PRIME +	28,542										
7																				
8																				
9	TOTAL Facility Related					\$ 500,000	\$ 318,743			\$ 28,542										
B. Non-Facility Related*																				
10	IRS, IDR, ETC	X	LATE FEES																	
11																				
12																				
13																				
14	TOTAL Non-Facility Related					\$ 0	\$ 0			\$ 0										
15	TOTALS (line 9+line14)					\$ 500,000	\$ 318,743			\$ 28,542										

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.		\$	38,875	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.)		\$	50,309	2
3. Under or (over) accrual (line 2 minus line 1).		\$	11,434	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	67,078	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.		\$	78,512	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	8
	2002	9
	2003	10
	2004	51,834 11
	2005	67,078 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:

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 HILLSIDE REHABILITATION & CARE CENTER COUNTY KENDALL

FACILITY IDPH LICENSE NUMBER 0047100

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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. <u>02-29-278-001</u>	<u>NURSING HOME</u>	\$ <u>62,253.82</u>	\$ <u>62,253.82</u>
2. <u>02-29-278-008</u>	<u></u>	\$ <u>2,253.50</u>	\$ <u>2,253.50</u>
3. <u>02-29-278-015</u>	<u></u>	\$ <u>2,571.04</u>	\$ <u>2,571.04</u>
4. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS		\$ <u>67,078.36</u>	\$ <u>67,078.36</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 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 HILLSIDE REHABILITATION & CARE CENTER

0047100

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,390 B. General Construction Type: Exterior MASONRY Frame BRICK Number of Stories 1

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>OFFICE BUILDING</u>		<u>2005</u>	<u>\$ 7,192</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 7,192	3

Facility Name & ID Number **HILLSIDE REHABILITATION & CARE CENTER**

0047100

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				\$	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	HEAT & SMOKE DETECTORS		2005	2,700	98	27.5	98		110
10	OUTDOOR LIGHTING		2005	2,450	163	15	163		184
11	SIDEWALKS		2005	3,250	217	15	217		244
12	BASEBOARD HEATER		2006	600	1	27.5	1		1
13	FIRESPRINKLER VALVE & ALARM PULL BOXES		2006	7,820	12	27.5	12		12
14	CARPETING		2006	716	143	5	143		143
15									
16									
17									
18									
19									
20									
21									
22	H & I PROPERTIES		2005	32,513	833	39	833		1,479
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70
			50,049		1,467		0	2,173

**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	\$ 4,804	\$ 1,633	\$ 480	\$ (1,153)		\$ 720	71
72	Current Year Purchases	14,830	2,966	742	(2,224)		742	72
73	Fully Depreciated Assets				0			73
74					0			74
75	TOTALS	\$ 19,634	\$ 4,599	\$ 1,222	\$ (3,377)		\$ 1,462	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				\$	\$	\$	0		\$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 0	\$ 0	\$ 0	\$ 0		\$ 0	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)	\$ 76,875	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 6,066	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 2,689	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (3,377)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,635	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: ELITE YORKVILLE, LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		79	04/05/05	\$ 346,020	9		3
4	Additions							4
5								5
6								6
7	TOTAL		79		\$ 346,020			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: \$ 12,337 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			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning 04/01/05

Ending 02/28/14

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

Fiscal Year Ending Annual Rent

12. /2007 \$ 346,020

13. /2008 \$ 346,020

14. /2009 \$ 346,020

* 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		Contract	Total
		1 Drop-outs	2 Completed		
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	\$		\$ 110,829	\$		\$ 110,829	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			19,356			19,356	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			118,932			118,932	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 prescrpts				74,950		74,950	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			\$		\$ 249,117	\$ 74,950		\$ 324,067	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 **HILLSIDE REHABILITATION & CARE CENTER** # **0047100** 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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 126,380	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (25,000))	677,580		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	53,334		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Real Estate Escrow Deposit</u>	47,531		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 904,825	\$ 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	16,820		15
16	Equipment, at Historical Cost	42,272		16
17	Accumulated Depreciation (book methods)	(18,802)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Deposit on Fixed Asset</u>	7,023		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 47,313	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 952,138	\$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 284,322	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	318,743		29
30	Accrued Salaries Payable	60,032		30
31	Accrued Taxes Payable (excluding real estate taxes)	30,454		31
32	Accrued Real Estate Taxes(Sch.IX-B)	67,078		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)	\$ 760,629	\$ 0	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)	\$ 0	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 760,629	\$ 0	46
47	TOTAL EQUITY (page 18, line 24)	\$ 191,509	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 952,138	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 213,349	1
2	Restatements (describe):		2
3	ROUNDING	(3)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 213,346	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(15,837)	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	(6,000)	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)	\$ (21,837)	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)	\$ 191,509	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	\$ 3,620,301	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,620,301	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	91,203	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 91,203	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	(634)	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)	\$ (634)	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,274	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,274	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)	\$ 3,713,144	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	515,140	31
32	Health Care	1,443,427	32
33	General Administration	924,425	33
	B. Capital Expense		
34	Ownership	477,951	34
	C. Ancillary Expense		
35	Special Cost Centers	324,067	35
36	Provider Participation Fee	43,253	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,728,263	40
41	Income before Income Taxes (line 30 minus line 40)**	(15,119)	41
42	Income Taxes	(718)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (15,837)	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 HILLSIDE REHABILITATION & CARE CENTER

0047100

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	1,721	1,985	\$ 71,616	\$ 36.08	1
2	Assistant Director of Nursing	1,739	1,915	49,602	25.90	2
3	Registered Nurses	11,799	12,991	301,117	23.18	3
4	Licensed Practical Nurses	5,671	6,387	142,932	22.38	4
5	CNAs & Orderlies	47,936	52,342	616,697	11.78	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,003	2,265	28,347	12.52	8
9	Activity Director	1,896	2,082	27,612	13.26	9
10	Activity Assistants	867	989	11,107	11.23	10
11	Social Service Workers	574	655	8,323	12.71	11
12	Dietician					12
13	Food Service Supervisor	1,870	2,086	34,459	16.52	13
14	Head Cook	6,215	6,906	65,860	9.54	14
15	Cook Helpers/Assistants	2,970	3,222	28,575	8.87	15
16	Dishwashers					16
17	Maintenance Workers	1,837	1,930	25,624	13.28	17
18	Housekeepers	7,466	8,337	87,843	10.54	18
19	Laundry	1,822	2,000	22,218	11.11	19
20	Administrator	1,840	2,080	82,472	39.65	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,921	2,188	43,045	19.67	23
24	Clerical	3,005	3,364	52,128	15.50	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	1,072	1,255	18,217	14.52	31
32	Other Health C: <u>MDS</u>	1,492	1,600	38,442	24.03	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	105,716	116,579	\$ 1,756,236 *	\$ 15.06	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	\$ 8,168	1-3	35
36	Medical Director	O	10,200	9-3	36
37	Medical Records Consultant	N	1,600	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	2,358	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	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	1,149	12-3	45
46	Other(specify)	S			46
47	<u>Program Consultant</u>		120	11-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 23,595		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
NANCY TETTEMER	ADMINISTRATOR		\$ 82,472	Workers' Compensation Insurance	\$ 59,410	IDPH License Fee	\$	
	ASST ADMIN		0	Unemployment Compensation Insurance	41,146	Advertising: Employee Recruitment	4,917	
				FICA Taxes	133,130	Health Care Worker Background Check	1,056	
				Employee Health Insurance	27,564	(Indicate # of checks performed 1056)		
				Employee Meals	0	Patient Background Checks	73 1,168	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	0	
				EMPLOYEE BENEFITS - OTHER	4,810	MARKETING/ADV/PROMO	10,930	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	10,890	
				PENSION/PROFIT SHARING PLANS	1,062	MGMT CO ALLOC	264	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	0	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense (0	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(5,580)	
						Yellow page advertising	(5,350)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 82,472	TOTAL (agree to Schedule V, line 22, col.8)	\$ 267,122	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 18,295	
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
HI CARE MANAGEMENT			\$ 222,690				Out-of-State Travel	\$
							In-State Travel	2,993
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 222,690				MGMT ALLOC	532
C. Professional Services							MARKETING TRAVEL	(462)
Vendor/Payee	Type		Amount				Seminar Expense	0
ACHIEVE HEALTHCARE	DATA PROCESSING		\$ 7,733					
IVANS	DATA PROCESSING		295				Entertainment Expense (
KRUPNICK, BOKOR	ACCOUNTING		17,550				(agree to Sch. V, line 24, col. 8)	
FIRST NATIONAL BANK	LEGAL		109				TOTAL	\$ 3,063
RICHARD PEELO & ASSOC	MEDICARE CONSULTANT		3,000					
STRATTON, GIGANTI	LEGAL		1,100					
SYSTEMATIC MANAGEMENT	MEDICARE B BILLING		5,032					
IL DEPT OF PUBLIC HEALTH	review fee for dining expansion		2,400					
HEALTHCARE HORIZONS	MEDICAID CONSULTANT		9,000					
MARCIA LATHROP	SIGN INTERPRETATION		280					
SEE SCHEDULE ATTACHED								
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 46,499	TOTAL		\$		

* Attach copy of IMRF notifications

**See instructions.

