



Facility Name & ID Number HILLCREST HEALTHCARE CENTER

# 0037572 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	84	Skilled (SNF)	84	30,660	1
2		Skilled Pediatric (SNF/PED)			2
3	84	Intermediate (ICF)	84	30,660	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	168	TOTALS	168	61,320	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
8	SNF			1,657	1,657	8
9	SNF/PED					9
10	ICF	54,193	316		54,509	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	54,193	316	1,657	56,166	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.59%

D. How many bed-hold days during this year were paid by the Department? 1,615 (Do not include bed-hold days in Section B.)

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

NONE

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 09/15/91

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 09/15/91 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 18 and days of care provided 1,657

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number **HILLCREST HEALTHCARE CENTER** # **0037572** Report Period Beginning: **01/01/2007** Ending: **12/31/2007**

**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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	193,275	17,789	10,160	221,224		221,224		221,224		1
2	Food Purchase		215,337		215,337	(13,140)	202,197	(502)	201,695		2
3	Housekeeping	195,157	36,032		231,189		231,189		231,189		3
4	Laundry	40,845	12,454		53,299		53,299		53,299		4
5	Heat and Other Utilities			153,867	153,867		153,867	13	153,880		5
6	Maintenance	32,450	29,117	56,789	118,356		118,356	8,218	126,574		6
7	Other (specify):* <b>SECURITY</b>	69,727		20,118	89,845		89,845	69	89,914		7
8	<b>TOTAL General Services</b>	531,454	310,729	240,934	1,083,117	(13,140)	1,069,977	7,798	1,077,775		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			20,100	20,100		20,100		20,100		9
10	Nursing and Medical Records	1,477,693	52,367	12,826	1,542,886		1,542,886	51,228	1,594,114		10
10a	Therapy	68,912	3,154	59,988	132,054		132,054	12,569	144,623		10a
11	Activities	97,053	48,712		145,765		145,765		145,765		11
12	Social Services	351,787			351,787		351,787		351,787		12
13	CNA Training										13
14	Program Transportation			456	456		456		456		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,995,445	104,233	93,370	2,193,048		2,193,048	63,797	2,256,845		16
	<b>C. General Administration</b>										
17	Administrative	103,172		270,000	373,172		373,172	(161,994)	211,178		17
18	Directors Fees										18
19	Professional Services			315,201	315,201		315,201	(250,499)	64,702		19
20	Dues, Fees, Subscriptions & Promotions			27,432	27,432		27,432	(18,500)	8,932		20
21	Clerical & General Office Expenses	80,829	17,890	168,314	267,033		267,033	(36,037)	230,996		21
22	Employee Benefits & Payroll Taxes			375,290	375,290	13,140	388,430		388,430		22
23	Inservice Training & Education			3,841	3,841		3,841	1,771	5,612		23
24	Travel and Seminar							2,619	2,619		24
25	Other Admin. Staff Transportation			14,903	14,903		14,903	10,228	25,131		25
26	Insurance-Prop.Liab.Malpractice			82,266	82,266		82,266	2,206	84,472		26
27	Other (specify):*							73,015	73,015		27
28	<b>TOTAL General Administration</b>	184,001	17,890	1,257,247	1,459,138	13,140	1,472,278	(377,191)	1,095,087		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,710,900	432,852	1,591,551	4,735,303		4,735,303	(305,596)	4,429,707		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	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	8,788
	REPAIRS & MAINTENANCE	1,372
		0
		10,160
3	<b>HOUSEKEEPING</b>	
		0
		0
		0
4	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	20,447
	ELECTRICITY	92,612
	WATER	25,675
	CABLE TV - LOBBY	15,133
		0
		153,867
6	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	9,815
	PAINTING & DECORATING	0
	BUILDING REPAIRS	3,365
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	18,060
	ELEVATOR MAINTENANCE & REPAIR	11,382
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,735
	FIRE SERVICE	10,432
		0
		0
		0
		0
		56,789
7	<b>OTHER</b>	
	SCAVENGER	20,118
	SECURITY SERVICE	0
		0
		0
		20,118
9	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	20,100
		20,100

LINE	SCHED REF	TOTAL
10	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	5,635
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,080
	PHARMACY CONSULTANT XVIII B 39-2	2,016
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B 47-2	0
	RN CONSULTANT XVIII B 38-2	0
	DENTAL SERVICES	4,095
	MEDICARE & PUBLIC AID CONSULTAN XVIII B 48-2	0
		12,826
10a	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	95
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	5,400
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	5,400
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
	THERAPY CONTRACT SERVICES	49,093
		59,988
11	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
		0
12	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
		0
		0
13	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	456
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	270,000
	<b>DIRECTORS FEES</b>	
18	DIRECTORS FEES	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	48,094
	ADMINISTRATIVE CONSULTANTS XIX C	228,000
	PROFESSIONAL FEES XIX C	39,107
		0
		315,201
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	18,955
	EMPLOYEE WANT ADS XIX F	2,862
	CONTRIBUTIONS VI 20 XIX F	2,500
	DUES & SUBSCRIPTIONS XIX F	65
	LICENSES & PERMITS XIX F	2,450
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	575
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	25
	PATIENT BACKGROUND CHECKS XIX F	0
		27,432
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,088
	EQUIPMENT REPAIR & MAINTENANCE	3,717
	OUTSIDE CLERICAL SERVICES	132,000
	PENALTIES / OVERDRAFT CHARGES VI 18	9,651
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	20,227
	MESSENGER SERVICE	1,631
		0
		168,314

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	204,179
	UNEMPLOYMENT COMPENSATION XIX D	38,858
	WORKERS COMPENSATION INSURANC XIX D	60,895
	HOSPITALIZATION INSURANCE XIX D	31,591
	EMPLOYEE BENEFITS - OTHER XIX D	38,813
	EMPLOYEE PHYSICAL EXAMS XIX D	954
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		375,290
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	3,841
		3,841
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	14,903
		14,903
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	82,266
	GENERAL INSURANCE EXPENSE	
		82,266
27	<b>OTHER</b>	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

1,591,551



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

#0037572

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			53,168	53,168		53,168	120,165	173,333			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,444	3,444		3,444	425,976	429,420			32
33	Real Estate Taxes			69,543	69,543		69,543	7,081	76,624			33
34	Rent-Facility & Grounds			1,039,994	1,039,994		1,039,994	(505,192)	534,802			34
35	Rent-Equipment & Vehicles			50,379	50,379		50,379	(24,916)	25,463			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,216,528	1,216,528		1,216,528	23,114	1,239,642			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		84,448	74,445	158,893		158,893	7,731	166,624			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			91,980	91,980		91,980		91,980			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		84,448	166,425	250,873		250,873	7,731	258,604			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,710,900	517,300	2,974,504	6,202,704		6,202,704	(274,751)	5,927,953			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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,998)	30		9
10	Interest and Other Investment Income	(10,085)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(502)	2		13
14	Non-Care Related Interest	(41)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(575)	20		17
18	Fines and Penalties	(9,651)	21		18
19	Entertainment				19
20	Contributions	(2,500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(18,955)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (44,307)		\$	30

<b>BHF USE ONLY</b>					
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	
		<b>Amount</b>	<b>Reference</b>	
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)	(230,444)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (230,444)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (274,751)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

ID# 0037572

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number HILLCREST HEALTHCARE CENTER# 0037572

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## 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	(502)	0	0	0	0	0	0	0	0	0	0	(502)	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	13	0	0	0	0	0	0	0	0	0	13	5
6	Maintenance	0	8,218	0	0	0	0	0	0	0	0	0	8,218	6
7	Other (specify):*	0	69	0	0	0	0	0	0	0	0	0	69	7
8	<b>TOTAL General Services</b>	<b>(502)</b>	<b>8,300</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>7,798</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	51,228	0	0	0	0	0	0	0	0	0	51,228	10
10a	Therapy	0	6,274	6,295	0	0	0	0	0	0	0	0	12,569	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>57,502</b>	<b>6,295</b>	<b>0</b>	<b>63,797</b>	<b>16</b>							
	<b>C. General Administration</b>													
17	Administrative	0	(270,000)	108,006	0	0	0	0	0	0	0	0	(161,994)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(259,272)	8,773	0	0	0	0	0	0	0	0	(250,499)	19
20	Fees, Subscriptions & Promotions	(22,030)	0	3,530	0	0	0	0	0	0	0	0	(18,500)	20
21	Clerical & General Office Expenses	(9,651)	(132,000)	105,614	0	0	0	0	0	0	0	0	(36,037)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	1,771	0	0	0	0	0	0	0	0	1,771	23
24	Travel and Seminar	0	0	2,619	0	0	0	0	0	0	0	0	2,619	24
25	Other Admin. Staff Transportation	0	0	10,228	0	0	0	0	0	0	0	0	10,228	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,206	0	0	0	0	0	0	0	0	2,206	26
27	Other (specify):*	0	0	73,015	0	0	0	0	0	0	0	0	73,015	27
28	<b>TOTAL General Administration</b>	<b>(31,681)</b>	<b>(661,272)</b>	<b>315,762</b>	<b>0</b>	<b>(377,191)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(32,183)</b>	<b>(595,470)</b>	<b>322,057</b>	<b>0</b>	<b>(305,596)</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	(1,998)	0	20,489	101,674	0	0	0	0	0	0	0	120,165	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10,126)	0	55,379	380,723	0	0	0	0	0	0	0	425,976	32
33	Real Estate Taxes	0	0	7,081	0	0	0	0	0	0	0	0	7,081	33
34	Rent-Facility & Grounds	0	0	0	(505,192)	0	0	0	0	0	0	0	(505,192)	34
35	Rent-Equipment & Vehicles	0	0	(24,916)	0	0	0	0	0	0	0	0	(24,916)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(12,124)</b>	<b>0</b>	<b>58,033</b>	<b>(22,795)</b>	<b>0</b>	<b>23,114</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	7,731	0	0	0	0	0	0	0	0	7,731	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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>7,731</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>7,731</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(44,307)</b>	<b>(595,470)</b>	<b>387,821</b>	<b>(22,795)</b>	<b>0</b>	<b>(274,751)</b>	<b>45</b>						

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				CAREPLUS MGMT	SKOKIE	MGMT/CLERICAL
				CAREPLUS REHABILITATIVE SERVICES		
SEE ATTACHED SCHEDULES					SKOKIE	THERAPY
				HILLCREST REALTY LLC		
					SKOKIE	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	\$ 270,000	CAREPLUS MGMT INC			(270,000)	1
2	V	19	ADMIN. CONSULTANT FEES	228,000	" "			(228,000)	2
3	V	19	DATA PROCESSING FEES	31,272	" "			(31,272)	3
4	V	21	CLERICAL FEES	132,000	" "			(132,000)	4
5	V				" "				5
6	V				" "				6
7	V	5	UTILITIES		" "		13	13	7
8	V	6	REPAIRS		" "		1,476	1,476	8
9	V	6	MAINTENANCE SALARIES		" "		6,742	6,742	9
10	V	7	SECURITY		" "		69	69	10
11	V	10	NURSING		" "		51,228	51,228	11
12	V	10a	THERAPY SALARIES		" "		4,767	4,767	12
13	V	10a	THERAPY SUPPLIES		" "		1,507	1,507	13
14	Total			\$ 661,272			\$ 65,802	\$ * (595,470)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17 ADMIN SALARIES	\$	CAREPLUS MGMT INC		\$ 108,006	\$ 108,006	15
16	V	19 PROFESSIONAL FEES		" "		8,773	8,773	16
17	V	20 DUES/LICENSES/WANT ADS		" "		3,530	3,530	17
18	V	21 OFFICE EXPENSES		" "		27,007	27,007	18
19	V	21 CLERICAL SALARIES		" "		78,607	78,607	19
20	V	23 SEMINARS		" "		1,771	1,771	20
21	V	24 TRAVEL		" "		2,619	2,619	21
22	V	25 TRANSPORTATION		" "		10,228	10,228	22
23	V	26 INSURANCE		" "		2,206	2,206	23
24	V	27 EMPLOYEE BENEFITS		" "		73,015	73,015	24
25	V	30 SL DEPRECIATION		" "		15,522	15,522	25
26	V	32 INTEREST-TAG MTG/LOC/EQ LOAN		" "		50,703	50,703	26
27	V	33 REAL ESTATE TAX		" "		7,081	7,081	27
28	V	35 EQUIP RENT/AUTO LEASE		" "		10,407	10,407	28
29	V							29
30	V							30
31	V							31
32	V	10a THERAPY SERVICES	59,988	CAREPLUS REHABILITATIVE SERVICES		66,283	6,295	32
33	V	39 ANCILLARY THERAPY	73,661	" "		81,392	7,731	33
34	V	35 EQUIPMENT RENT EXPENSE	35,323	" "			(35,323)	34
35	V	30 SL DEPRECIATION		" "		4,967	4,967	35
36	V	32 INTEREST		" "		4,676	4,676	36
37	V							37
38	V							38
39	Total		\$ 168,972			\$ 556,793	\$ * 387,821	39

\* 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	34 RENT	\$ 505,192	HILLCREST REALTY LLC		\$	(505,192)
16	V	30 SL DEPRECIATION		" "		101,674	101,674
17	V	32 INTEREST		" "		380,723	380,723
18	V			" "			
19	V			" "			
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 505,192			\$ 482,397	\$ * (22,795)

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

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

## VII. RELATED PARTIES (continued)

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

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

1	2	3	4	5	6		7		8	9	
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**				
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference		
1	<b>CAREPLUS MGMT ALLOCATIONS:</b>							\$		1	
2	SHERWIN RAY	PRESIDENT	ADMIN/FINANCE	25.89	SEE ATTACHED	7.6	12.60	SALARY	20,790	17-7	2
3	JAKOB BAKST	DIR OPERATIONS	ADMIN/CONS.	26.73	SCHEDULES	7.6	12.60	" "	20,790	17-7	3
4	ROSLYN INDICH	EXECUTIVE ASST	A/P MGMT	2.38	" "	7.6	12.60	" "	6,228	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 47,808		13

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

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

Facility Name & ID Number HILLCREST HEALTHCARE CENTER

# 0037572

Report Period Beginning:

01/01/2007

Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization CAREPLUS MANAGEMENT INC  
 Street Address 8320 SKOKIE BLVD  
 City / State / Zip Code SKOKIE, IL 60077  
 Phone Number ( 847)329-1555  
 Fax Number ( 847)329-9555

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1		CENSUS DAYS			\$	\$		\$	1
2	5	UTILITIES	445,767	11 FACILITIES	100		56,166	13	2
3	6	REPAIRS	445,767	11 FACILITIES	11,715		56,166	1,476	3
4	6	MAINTENANCE SALARIES	445,767	11 FACILITIES	53,507	53,507	56,166	6,742	4
5	7	SECURITY	445,767	11 FACILITIES	548		56,166	69	5
6	10	NURSING	445,767	11 FACILITIES	406,577	406,577	56,166	51,228	6
7	10a	THERAPY SALARIES	445,767	11 FACILITIES	37,834	37,834	56,166	4,767	7
8	10a	THERAPY SUPPLIES	445,767	11 FACILITIES	11,963		56,166	1,507	8
9	17	ADMIN SALARIES	445,767	11 FACILITIES	857,197	857,197	56,166	108,006	9
10	19	PROFESSIONAL FEES	445,767	11 FACILITIES	69,630		56,166	8,773	10
11	20	DUES/LICENSES/WANT ADS	445,767	11 FACILITIES	28,013		56,166	3,530	11
12	21	OFFICE EXPENSES	445,767	11 FACILITIES	214,347		56,166	27,007	12
13	21	CLERICAL SALARIES	445,767	11 FACILITIES	623,871	623,871	56,166	78,607	13
14	23	SEMINARS	445,767	11 FACILITIES	14,052		56,166	1,771	14
15	24	TRAVEL	445,767	11 FACILITIES	20,788		56,166	2,619	15
16	25	TRANSPORTATION	445,767	11 FACILITIES	81,177		56,166	10,228	16
17	26	INSURANCE	445,767	11 FACILITIES	17,511		56,166	2,206	17
18	27	EMPLOYEE BENEFITS	445,767	11 FACILITIES	579,494		56,166	73,015	18
19	30	SL DEPRECIATION	445,767	11 FACILITIES	123,201		56,166	15,522	19
20	32	INTEREST-TAG MTG/LOC/EQ LOAN	445,767	11 FACILITIES	402,408		56,166	50,703	20
21	33	REAL ESTATE TAX	445,767	11 FACILITIES	56,199		56,166	7,081	21
22	35	EQUIP RENT/AUTO LEASE	445,767	11 FACILITIES	82,599		56,166	10,407	22
23									23
24									24
25	TOTALS				\$ 3,692,731	\$ 1,978,986		\$ 465,277	25

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

# **0037572**

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Interest Expense	10
		YES	NO				Original	Balance				
<b>A. Directly Facility Related</b>												
<b>Long-Term</b>												
1	RELATED PARTY: HILLCREST REALTY LLC						\$	\$			\$	1
2	LAKE FOREST BK		X	MORTGAGE		02/07	6,400,000	6,267,156	02/22/12	7.1500	372,347	2
3	LOAN COSTS		X	LOAN COSTS	W/O OVER LOAN	02/07	47,863	39,487	02/22/12		8,376	3
4												4
5	CAREPLUS MGT - FIRST BK	X		CAPITAL IMPROVEMENT	\$5,065.78	01/04	213,229	6,559	01/09	PRIME+	2,999	5
<b>Working Capital</b>												
6	INSURANCE FINANCING		X	INSUR. FINANCE							404	6
7	CAREPLUS MGMT ALLOCATION: TAG MTG INT/LOC/EQ LOAN										50,703	7
8	CAREPLUS REHAB ALLOCATION: EQUIP LOAN										4,676	8
9	TOTAL Facility Related				\$5,065.78		\$ 6,661,092	\$ 6,313,202			\$ 439,505	9
<b>B. Non-Facility Related*</b>												
10	IRS, IDR, ETC		X	LATE FEES							41	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ 41	14
15	TOTALS (line 9+line14)						\$ 6,661,092	\$ 6,313,202			\$ 439,546	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ N/A                      Line # 32-7

\* 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 2006 report.

\$ **74,640** 1

2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)

\$ **71,733** 2

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

\$ **(2,907)** 3

4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)

\$ **72,450** 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.

\$ **69,543** 7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	<b>71,585</b>	8
	2003	<b>71,328</b>	9
	2004	<b>73,735</b>	10
	2005	<b>73,897</b>	11
	2006	<b>71,733</b>	12

**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 2006 TAX BILL.**

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2006	\$	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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

**2006 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME HILLCREST HEALTHCARE CENTER COUNTY WILL

FACILITY IDPH LICENSE NUMBER 0037572

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>30-07-11-101-003-0000</u>	<u>NURSING HOME</u>	\$ <u>71,732.80</u>	\$ <u>71,732.80</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>71,732.80</u>	\$ <u>71,732.80</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**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 HEALTHCARE CENTER

# 0037572

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 23,039 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 3

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)  
 List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

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

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

Nature of Costs:

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>RELATED PARTY:HILLCREST REALTY LLC</u>			\$	<u>1</u>
2	<u>NURSING HOME</u>	<u>132,928</u>	<u>2007</u>	<u>336,000</u>	<u>2</u>
3	<b>TOTALS</b>	<u>132,928</u>		\$ <u>336,000</u>	<u>3</u>

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

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

**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	<b>RELATED PARTY: HILLCREST REALTY LLC:</b>			\$	\$		\$	\$	\$	4
5	168	2007		5,288,123	84,874	27.5	84,874		84,874	5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	LEASEHOLD IMPROVEMENTS		1991	6,230	198	31.5	198		3,202	9
10	LEASEHOLD IMPROVEMENTS		1992	48,072	1,525	31.5	1,526	1	23,653	10
11	LEASEHOLD IMPROVEMENTS		1993	33,291	981	31.5	1,057	76	15,326	11
12	LEASEHOLD IMPROVEMENTS		1994	10,172	261	39	261		3,491	12
13	ROOF REPAIR		1995	5,221	134	39	134		1,647	13
14	CONDENSING UNITS		1996	3,924	101	39	101		1,174	14
15	CEILING TILES		1996	1,334	34	39	34		390	15
16	ROOF REPAIR		1996	8,079	207	39	207		2,355	16
17	DOORS		1997	1,078	28	39	28		295	17
18	WINDOWS & ROOF VENTILATOR		1997	3,572	92	39	92		924	18
19	WINDOWS		1998	12,100	309	39	310	1	2,977	19
20	ROOF REPAIRS/DOORS/ELEC. REPAIRS/LOT LIGHTS		1998	23,693	607	39	607		5,803	20
21	WALLCOVER/RAILS/NURSE STNS/WINDOW TREATMENTS		1998	155,436	3,985	39	3,985		37,762	21
22	WINDOWS/DECORATING/CEILING TILE/ROOF REPAIR		1999	70,751	1,814	39	1,814		15,464	22
23	WINDOWS/FLOORING/DOOR		2000	12,169	442	27.5	442		3,376	23
24	CARPETING		2000	2,088	95	10	209	114	1,567	24
25	DOORS/ELEVATOR REPAIRS/SECURITY SYSTEM UPGRADE		2001	42,268	1,536	27.5	1,537	1	10,327	25
26	FENCE		2001	10,361	691	15	691		4,491	26
27	ROOF REPAIRS/CEILING TILE/FIRE DAMPERS/LIGHTING		2001	43,148	1,568	27.5	1,569	1	9,717	27
28	ROOF REPAIRS/HEAT/AC REPAIRS		2002	12,346	450	27.5	449	(1)	2,428	28
29	FENCE		2002	4,573	305	15	305		1,677	29
30	DOOR REPLACEMENTS/DUCTWORK-FIRE CODE		2003	7,297	266	27.5	265	(1)	1,239	30
31	DURO-LAST ROOF SYSTEM		2003	66,500	3,355	27.5	3,355		14,306	31
32	WALL A/C UNIT INSTALLATIONS / ELEVATOR BUTTONS		2003	92,265	2,418	27.5	2,418		10,579	32
33	FENCE / PARKING LOT SEAL		2003	8,816	588	15	588		2,646	33
34	EXTERIOR DOORS		2004	2,807	102	27.5	102		370	34
35	BATHROOM REMODELING		2004	2,500	91	27.5	91		322	35
36	SPRINKLERS/PIPING		2004	1,881	68	27.5	68		235	36

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

See Page 12A, Line 70 for total

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

Facility Name &amp; ID Number HILLCREST HEALTHCARE CENTER

# 0037572

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	WALL UNIT A/C	2005	\$ 7,074	\$ 257	27.5	\$ 257		\$ 734	37
38	BATHROOMS/KITCHEN REMODELING	2005	51,970	1,890	27.5	1,890		4,799	38
39	FIRE ALARM SYSTEM	2005	61,833	2,248	27.5	2,248		5,948	39
40	DOORS	2006	7,026	256	27.5	255	(1)	457	40
41	WALL A/C UNITS / SMOKE ROOM EXHAUST / TILE	2006	29,088	1,057	27.5	1,058	1	1,275	41
42	WALL A/C /DOORS/LOCKERS/GUTTERS/ELECTRICAL	2007	45,233	1,019	27.5	1,019		1,019	42
43	CEDAR FENCE	2007	9,600	320	15	320		320	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	RELATED PARTY ALLOCATION - CAREPLUS REHAB								56
57	WALL UNIT A/C'S,BRICKWORK,DRYWALL,ELECTRICAL	2004	29,464	756	39	756		2,866	57
58	CEILINGS/DRYWALL	2004	6,913	178	39	178		678	58
59	FIRE DAMPERS/DUCTWORK	2004	10,058	258	39	258		880	59
60									60
61									61
62	RELATED PARTY ALLOCATION - CAREPLUS MGMT								62
63	BUILDING-TAG-18 PROPERTIES	2004	58,244	2,022	39	2,022		5,097	63
64	BUILDING IMPROVEMENTS-TAG-18 PROPERTIES	2004	22,882	1,197	39	1,197		3,015	64
65	BUILDING IMPROVEMENTS-CAREPLUS MGMT	2007		8	39	8			65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,319,480	\$ 118,591		\$ 118,783	\$ 192	\$ 289,705	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 230,346	\$ 15,417	\$ 18,205	\$ 2,788	8-15 YRS	\$ 144,495	71
72	Current Year Purchases	27,355	5,471	1,145	(4,326)	10-15 YRS	1,145	72
73	Fully Depreciated Assets							73
74	<b>**REL'D PARTY-SL DEPN:CAREPL MGT, 12,295 /CP REHAB, 3,775/HILLCREST LLC, 16,800</b>		32,870	32,870		8-15 YRS		74
75	TOTALS	\$ 257,701	\$ 53,758	\$ 52,220	\$ (1,538)		\$ 145,640	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY VAN	'02 DODGE RAM BR150	2006	\$ 9,319	\$ 2,982	\$ 2,330	\$ (652)	4 YRS	\$ 3,495	76
77										77
78										78
79										79
80	TOTALS			\$ 9,319	\$ 2,982	\$ 2,330	\$ (652)		\$ 3,495	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)	\$ 6,922,500	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 175,331	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 173,333	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,998)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 438,840	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: DRAPER PLAZA THROUGH 2/07 - THEN HILLCREST REALTY (RELATED PARTY)

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

If NO, see instructions.  YES  NO

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>TO PRIOR OWNER</u>	<u>168</u>	<u>09/15/91</u>	\$ <u>534,802</u>	<u>15</u>	<u>3</u>
4	Additions			<u>(INCLUDES BONUS RENT DUE AT CLOSING)</u>			<u>4</u>
5		<u>TO RELATED PARTY</u>		<u>505,192</u>			<u>5</u>
6							<u>6</u>
7	TOTAL		<u>168</u>	\$ <u>1,039,994</u>			<u>7</u>

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: PURCHASED 2/07 \*

**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: \$ 50,379 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

10. Effective dates of current rental agreement:

Beginning 09/15/91

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ /2008 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

\* 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><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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	\$		\$ 6,251	\$		\$ 6,251	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			108			108	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			67,303			67,303	4
5	Physician Care	39-3	visits			783			783	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				79,009		79,009	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39-2/39-3								12
13	MED.SUPPLIES/LAB/RENTALS Other (specify):	39-2					5,439		5,439	13
14	<b>TOTAL</b>			\$		\$ 74,445	\$ 84,448		\$ 158,893	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 &amp; ID Number HILLCREST HEALTHCARE CENTER

# 0037572

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 492	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 110,000 )	2,342,995		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	323,947		5
6	Prepaid Insurance	85,481		6
7	Other Prepaid Expenses	106,538		7
8	Accounts Receivable (owners or related parties)	25,000		8
9	Other(specify): R.E.TAX ESCROW	26,927		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 2,911,380	\$	10
	<b>B. Long-Term Assets</b>			
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	944,114		15
16	Equipment, at Historical Cost	267,020		16
17	Accumulated Depreciation (book methods)	(413,101)		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): SECURITY DEPOSITS	17,260		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 815,293	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 3,726,673	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 821,258	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,824		28
29	Short-Term Notes Payable	6,559		29
30	Accrued Salaries Payable	176,755		30
31	Accrued Taxes Payable (excluding real estate taxes)	14,486		31
32	Accrued Real Estate Taxes(Sch.IX-B)	72,450		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,094,332	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>DUE TO LLC</u>	428,962		43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 428,962	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,523,294	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 2,203,379	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 3,726,673	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,618,692</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>ROUNDING</b>	<b>3</b>	<b>3</b>
<b>4</b>	<b>IL REPLACEMENT TAX</b>	<b>(4,160)</b>	<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,614,535</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>588,844</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>588,844</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>2,203,379</b>	<b>24</b> *

\* 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	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 6,751,009	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,751,009	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	30,454	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 30,454	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	10,085	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 10,085	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,791,548	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,083,117	31
32	Health Care	2,193,048	32
33	General Administration	1,459,138	33
	<b>B. Capital Expense</b>		
34	Ownership	1,216,528	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	158,893	35
36	Provider Participation Fee	91,980	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,202,704	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	588,844	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 588,844	43

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

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

TAX RETURN PREPARED ON CASH BASIS

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

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

Facility Name & ID Number HILLCREST HEALTHCARE CENTER

# 0037572

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

**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	1,644	2,309	\$ 77,737	\$ 33.67	1
2	Assistant Director of Nursing	1,596	2,261	66,124	29.25	2
3	Registered Nurses	9,809	10,616	270,806	25.51	3
4	Licensed Practical Nurses	21,214	22,902	515,070	22.49	4
5	CNAs & Orderlies	39,251	44,096	418,028	9.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,667	6,632	68,912	10.39	8
9	Activity Director	2,026	2,135	42,597	19.95	9
10	Activity Assistants	6,084	6,858	54,456	7.94	10
11	Social Service Workers	20,461	21,738	351,787	16.18	11
12	Dietician					12
13	Food Service Supervisor	1,964	2,095	39,129	18.68	13
14	Head Cook	4,666	5,292	46,144	8.72	14
15	Cook Helpers/Assistants	12,934	14,536	108,002	7.43	15
16	Dishwashers					16
17	Maintenance Workers	2,017	2,221	32,450	14.61	17
18	Housekeepers	23,013	24,801	195,157	7.87	18
19	Laundry	3,775	4,700	40,845	8.69	19
20	Administrator	2,042	2,227	80,654	36.22	20
21	Assistant Administrator	1,150	1,252	22,518	17.99	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,415	5,919	80,829	13.66	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,683	3,008	28,791	9.57	31
32	Other Health C: <u>MDS/CPC</u>	3,107	3,454	101,137	29.28	32
33	Other(specify) <u>SECURITY</u>	7,241	7,960	69,727	8.76	33
34	TOTAL (lines 1 - 33)	177,759	197,012	\$ 2,710,900 *	\$ 13.76	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	\$ 8,788	1-3	35
36	Medical Director	O	20,100	9-3	36
37	Medical Records Consultant	N	1,080	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	2,016	10-3	39
40	Physical Therapy Consultant	L	5,400	10a-3	40
41	Occupational Therapy Consultant	Y	5,400	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 42,784		49

**C. CONTRACT NURSES**

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





Facility Name & ID Number HILLCREST HEALTHCARE CENTER# 0037572Report Period Beginning: 01/01/2007Ending: 12/31/2007**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? NO  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 191 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 91,980  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 13,140 Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 5%  
d. Have vehicle usage logs been maintained? NO  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
g. Does the facility transport residents to and from day training? NO  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees