

		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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

<p>I. IDPH License ID Number: <u>0047100</u></p> <p>Facility Name: <u>HILLSIDE REHAB & CARE CENTER</u></p> <p>Address: <u>1308 GAME FARM ROAD</u> <u>YORKVILLE</u> <u>60560</u> Number City Zip Code</p> <p>County: <u>KENDALL</u></p> <p>Telephone Number: <u>(217) 528-0044</u> Fax # <u>(217) 528-3412</u></p> <p>HFS ID Number: <u>20-255402301</u></p> <p>Date of Initial License for Current Owners: <u>04/01/2005</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2007</u> to <u>12/31/2007</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>ROBERT HEDGES</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>MEMBER</u></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u></td> </tr> <tr> <td>(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> </tr> <tr> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>ROBERT HEDGES</u> (Date) _____		(Title) <u>MEMBER</u>	Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>	(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>
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Facility Name & ID Number HILLSIDE REHAB & CARE CENTER

0047100 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	<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>563</u>	<u>102</u>	<u>3,400</u>	<u>4,065</u>	8
9	SNF/PED					9
10	ICF	<u>10,988</u>	<u>7,745</u>	<u>173</u>	<u>18,906</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>11,551</u>	<u>7,847</u>	<u>3,573</u>	<u>22,971</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.66%

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 02/01/03

J. Was the facility purchased or leased after January 1, 1978?
YES Date 02/01/03 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 3,400

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRAUAL 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 **HILLSIDE REHAB & CARE CENTER** # **0047100** 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
	A. General Services										
1	Dietary	133,681	11,902	8,399	153,982		153,982		153,982		1
2	Food Purchase		96,135		96,135		96,135	(8)	96,127		2
3	Housekeeping	97,229	7,374		104,603		104,603		104,603		3
4	Laundry	17,904	7,305	27,666	52,875		52,875		52,875		4
5	Heat and Other Utilities			71,521	71,521		71,521	1,080	72,601		5
6	Maintenance	24,001	10,901	23,246	58,148		58,148	5,140	63,288		6
7	Other (specify):*			12,089	12,089		12,089		12,089		7
8	TOTAL General Services	272,815	133,617	142,921	549,353		549,353	6,212	555,565		8
	B. Health Care and Programs										
9	Medical Director			9,900	9,900		9,900		9,900		9
10	Nursing and Medical Records	1,232,381	76,647	3,489	1,312,517		1,312,517		1,312,517		10
10a	Therapy	31,388	590		31,978		31,978		31,978		10a
11	Activities	36,745	3,035	4,090	43,870		43,870		43,870		11
12	Social Services	1,485		1,006	2,491		2,491		2,491		12
13	CNA Training										13
14	Program Transportation			3,931	3,931		3,931		3,931		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,301,999	80,272	22,416	1,404,687		1,404,687		1,404,687		16
	C. General Administration										
17	Administrative	84,946		147,332	232,278		232,278	(79,337)	152,941		17
18	Directors Fees										18
19	Professional Services			42,519	42,519		42,519	(8,764)	33,755		19
20	Dues, Fees, Subscriptions & Promotions			33,591	33,591		33,591	(10,076)	23,515		20
21	Clerical & General Office Expenses	99,957	12,184	88,637	200,778		200,778	(64,085)	136,693		21
22	Employee Benefits & Payroll Taxes			269,721	269,721		269,721		269,721		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,183	2,183		2,183	740	2,923		24
25	Other Admin. Staff Transportation			1,603	1,603		1,603	1,215	2,818		25
26	Insurance-Prop.Liab.Malpractice			48,254	48,254		48,254	1,988	50,242		26
27	Other (specify):*			5,755	5,755		5,755	10,577	16,332		27
28	TOTAL General Administration	184,903	12,184	639,595	836,682		836,682	(147,742)	688,940		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,759,717	226,073	804,932	2,790,722		2,790,722	(141,530)	2,649,192		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	8,399
	REPAIRS & MAINTENANCE	0
		0
		8,399
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	187
	CONSTRUCTED SERVICES	27,479
		27,666
5	HEAT & OTHER UTILITIES	
	GAS HEAT	1,163
	ELECTRICITY	58,217
	WATER	5,572
	CABLE TV - LOBBY	6,569
		0
		71,521
6	MAINTENANCE	
	GROUNDS MAINTENANCE	4,958
	PAINTING & DECORATING	0
	BUILDING REPAIRS	4,592
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	6,906
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,997
	FIRE SERVICE	4,793
		0
		0
		0
		0
		23,246
7	OTHER	
	SCAVENGER	12,089
	SECURITY SERVICE	0
		0
		0
		12,089
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	9,900
		9,900

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	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	1,215
	PHARMACY CONSULTANT XVIII B 39-2	2,274
	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
		3,489
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	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	4,090
		0
		4,090
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	1,006
	SOCIAL WORKER XVIII B 45-2	0
		0
		1,006
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	3,931
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	147,332
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	8,568
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	33,951
		0
		42,519
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	5,945
	EMPLOYEE WANT ADS XIX F	7,885
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	8,559
	LICENSES & PERMITS XIX F	2,768
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	4,642
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,872
	PATIENT BACKGROUND CHECKS XIX F	1,920
		33,591
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	5,518
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	7,503
	HOME OFFICE EXPENSE	60,000
	THEFT & DAMAGE LOSS	0
	TELEPHONE	15,616
	MESSENGER SERVICE	0
		0
		88,637

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	134,255
	UNEMPLOYMENT COMPENSATION XIX D	39,214
	WORKERS COMPENSATION INSURANC XIX D	61,033
	HOSPITALIZATION INSURANCE XIX D	24,346
	EMPLOYEE BENEFITS - OTHER XIX D	6,050
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	4,823
	CHICAGO HEAD TAX XIX D	0
		0
		269,721
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	2,183
	TRAVEL XIX G	0
		2,183
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	1,603
		1,603
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	48,254
		48,254
27	OTHER	
	BAD DEBTS VI 24	5,755
		5,755

GRAND TOTAL COLUMN 3 OTHER

804,932

**HILLSIDE REHAB & CARE CENTER
SCHEDULES
12/31/2007**

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

TOTAL FOOD PURCHASE	96,135
LESS SALES TAX	<u>(8)</u>
NET FOOD	96,127

TOTAL PATIENT CENSUS	22,971
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	68,913

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	68,913
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	68,913

NET FOOD	96,127
DIVIDE TOTAL MEALS/YEAR	<u>68,913</u>

COST PER MEAL	1.39
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

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

#0047100

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			6,782	6,782		6,782	(3,016)	3,766			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			32,594	32,594		32,594	(4,102)	28,492			32
33	Real Estate Taxes			68,593	68,593		68,593	953	69,546			33
34	Rent-Facility & Grounds			346,020	346,020		346,020		346,020			34
35	Rent-Equipment & Vehicles			17,678	17,678		17,678		17,678			35
36	Other (specify):* amort comp soft			7,307	7,307		7,307		7,307			36
37	TOTAL Ownership			478,974	478,974		478,974	(6,165)	472,809			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		157,697	183,232	340,929		340,929		340,929			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			43,253	43,253		43,253		43,253			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		157,697	226,485	384,182		384,182		384,182			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,759,717	383,770	1,510,391	3,653,878		3,653,878	(147,695)	3,506,183			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	BHF 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	(3,849)	30		9
10	Interest and Other Investment Income	(5,191)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(8)	2		13
14	Non-Care Related Interest	(1,052)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(7,503)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,755)	27		24
25	Fund Raising, Advertising and Promotional	(5,945)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,642)	20		28
29	Other-Attach Schedule	(31,434)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (65,379)		\$	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)	(82,316)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (82,316)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (147,695)		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

HILLSIDE REHAB & CARE CENTER

ID# 0047100

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	STAFF TRANSPORTATION MARKETING	\$ (202)	25	1
2			21	2
3	MARKETING SALARY	(22,032)	21	3
4	PROF FEES - HEALTHCARE HORIZONS	(9,200)	19	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	(31,434)		49

STATE OF ILLINOIS

Summary A

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

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	(8)	0	0	0	0	0	0	0	0	0	0	(8)	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	1,080	0	0	0	0	0	0	0	0	0	1,080	5
6	Maintenance	0	5,140	0	0	0	0	0	0	0	0	0	5,140	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(8)	6,220	0	6,212	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	(79,337)	0	0	0	0	0	0	0	0	0	(79,337)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(9,200)	436	0	0	0	0	0	0	0	0	0	(8,764)	19
20	Fees, Subscriptions & Promotions	(10,587)	511	0	0	0	0	0	0	0	0	0	(10,076)	20
21	Clerical & General Office Expenses	(29,535)	(34,550)	0	0	0	0	0	0	0	0	0	(64,085)	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	0	740	0	0	0	0	0	0	0	0	0	740	24
25	Other Admin. Staff Transportation	(202)	1,417	0	0	0	0	0	0	0	0	0	1,215	25
26	Insurance-Prop.Liab.Malpractice	0	1,988	0	0	0	0	0	0	0	0	0	1,988	26
27	Other (specify):*	(5,755)	16,332	0	0	0	0	0	0	0	0	0	10,577	27
28	TOTAL General Administration	(55,279)	(92,463)	0	(147,742)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(55,287)	(86,243)	0	(141,530)	29								

STATE OF ILLINOIS

Summary B

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

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(3,849)	0	833	0	0	0	0	0	0	0	0	(3,016)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,243)	0	2,141	0	0	0	0	0	0	0	0	(4,102)	32
33	Real Estate Taxes	0	0	953	0	0	0	0	0	0	0	0	953	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	(10,092)	0	3,927	0	(6,165)	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)	(65,379)	(86,243)	3,927	0	(147,695)	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	SPRINGFIELD	MANAGEMENT
ROBERT HEDGES	50	SEE ATTACHED		MANAGEMENT		
				HEALTHCARE	SPRINGFIELD	NURSING
				HORIZONS		CONSULTANT
				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	\$ 147,332	HI CARE MANAGEMENT		\$	\$ (147,332)	1
2	V	21 HOME OFFICE EXPENSE	60,000				(60,000)	2
3	V	5 UTILITIES				1,080	1,080	3
4	V	6 MAINTENANCE				5,140	5,140	4
5	V	17 ADMINISTRATIVE				67,995	67,995	5
6	V	19 PROFESSIONAL FEES				436	436	6
7	V	20 DUES & SUBSCRIPTION				511	511	7
8	V	21 OFFICE EXPENSE				25,450	25,450	8
9	V	24 TRAVEL & SEMINARS				740	740	9
10	V	25 TRANSPORTATION				1,417	1,417	10
11	V	26 INSURANCE				1,988	1,988	11
12	V	27 PAYROLL TAXES & GRP INS				16,332	16,332	12
13	V							13
14	Total		\$ 207,332			\$ 121,089	\$ * (86,243)	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				2,141	2,141	16
17	V	33 REAL ESTATE TAXES				953	953	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		\$			\$ 3,927	\$ * 3,927	39

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

Facility Name & ID Number HILLSIDE REHAB & CARE CENTER # 0047100 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 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		SEE	ATTACHED	SALARY	\$ 20,536	17-7	1
2	TOTAL ALLOWABLE SALARY RECEIVED FROM HI CARE \$165,000										2
3											3
4	WILLIAM IRVINE	VICE PRESIDENT	OFFICE MGMT.	50.00		SEE	ATTACHED	SALARY	20,536	17-7	4
5	TOTAL ALLOWABLE SALARY RECEIVED FROM HI CARE \$165,000										5
6											6
7	MARTHA IRVINE	BOOKKEEPING				SEE	ATTACHED	SALARY	1,798	21-7	7
8	TOTAL SALARY RECEIVED FROM HI CARE \$14,446										8
9											9
10	DEREK HEDGES	SPECIAL PROJECTS MNGR				SEE	ATTACHED	SALARY	9,062	17-7	10
11	TOTAL SALARY RECEIVED FROM HI CARE \$72,810										11
12											12
13								TOTAL	\$ 51,932		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 REHAB & CARE CENTER**

0047100 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 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	184,560	7	\$ 8,675	22,971	\$ 1,080	1	
2	6	MAINTENANCE	PER RESIDENT DAY	184,560	7	41,300	37,474	22,971	5,140	2
3	17	OFFICER SALARY-B HEDGES	PER RESIDENT DAY	184,560	7	165,000	165,000	22,971	20,536	3
4	17	OFFICER SALARY-B. IRVINE	PER RESIDENT DAY	184,560	7	165,000	165,000	22,971	20,536	4
5	17	DIRECTOR OF OPERATIONS	PER RESIDENT DAY	184,560	7	69,647	69,647	22,971	8,669	5
6	17	DIRECTOR OF FINANCE	PER RESIDENT DAY	184,560	7	73,854	73,854	22,971	9,192	6
7	17	SPECIAL PROJ MNGR-DEREK	PER RESIDENT DAY	184,560	7	72,810	72,810	22,971	9,062	7
8	19	PROFESSIONAL FEES	PER RESIDENT DAY	184,560	7	3,500		22,971	436	8
9	20	DUES & SUBSCRIPTION	PER RESIDENT DAY	184,560	7	4,105		22,971	511	9
10	21	OFFICE EXPENSE	PER RESIDENT DAY	184,560	7	204,479	141,575	22,971	25,450	10
11	24	TRAVEL & SEMINARS	PER RESIDENT DAY	184,560	7	5,945		22,971	740	11
12	25	TRANSPORTATION	PER RESIDENT DAY	184,560	7	11,383		22,971	1,417	12
13	26	INSURANCE	PER RESIDENT DAY	184,560	7	15,972		22,971	1,988	13
14	27	PAYROLL TAXES & GRP INS	PER RESIDENT DAY	184,560	7	131,223		22,971	16,332	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 972,893	\$ 725,360		\$ 121,089	25

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

0047100 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

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	\$	79	\$ 833	1
2	32	INTEREST	639	7	17,316		79	2,141	2
3	33	REAL ESTATE	639	7	7,709		79	953	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				\$ 31,766	\$		\$ 3,927	25

Facility Name & ID Number

HILLSIDE REHAB & CARE CENTER

0047100

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		3	4	5	6		7	8	9	10					
		Related**					Monthly Payment Required	Date of Note					Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1							\$	\$			\$	1					
2	US BANK (HI PROP)		X	MORTGAGE (office)		6/29/05		32,513	6/29/12	0.0635	2,141	2					
3												3					
4												4					
5												5					
Working Capital																	
6	COLE TAYLOR BANK		X	WORKING CAPITAL	INTEREST	11/05/05	500,000	411,607	REVOLV	PRIME+	31,542	6					
7												7					
8												8					
9	TOTAL Facility Related						\$ 500,000	\$ 444,120			\$ 33,683	9					
B. Non-Facility Related*																	
10	IRS, IDR, ETC		X	LATE FEES							1,052	10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$ 1,052	14					
15	TOTALS (line 9+line14)						\$ 500,000	\$ 444,120			\$ 34,735	15					

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

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2006 report.	\$	67,078	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.)	\$	67,835	2
3. Under or (over) accrual (line 2 minus line 1).	\$	757	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	67,836	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.	\$	68,593	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	_____	8
	2003	_____	9
	2004	51,834	10
	2005	67,078	11
	2006	67,835	12

FOR BHF USE ONLY			
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

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.

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 HILLSIDE REHAB & 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 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>02-29-278-001</u>	<u>NURSING HOME</u>	\$ <u>62,956.54</u>	\$ <u>62,956.54</u>
2. <u>02-29-278-008</u>	<u>NURSING HOME</u>	\$ <u>2,278.98</u>	\$ <u>2,278.98</u>
3. <u>02-29-278-015</u>	<u>NURSING HOME</u>	\$ <u>2,600.34</u>	\$ <u>2,600.34</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>67,835.86</u>	\$ <u>67,835.86</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 HILLSIDE REHAB & CARE CENTER

0047100

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

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

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		208
10	OUTDOOR LIGHTING		2005	2,450	163	15	163		347
11	SIDEWALKS		2005	3,250	217	15	217		461
12	BASEBOARD HEATER		2006	600	22	27.5	22		23
13	FIRESPRINKLER VALVE & ALARM PULL BOXES		2006	7,820	284	27.5	284		296
14	CARPETING		2006	716	229	5	143	(86)	286
15	RECEPTACLES		2007	2,549	43	27.5	43		43
16									
17									
18									
19									
20									
21									
22	H & I PROPERTIES		2005	32,513	833	39	833		2,312
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)		\$ 52,598	\$ 1,889		\$ 1,803	\$ (86)	\$ 3,976	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	\$ 19,634	\$ 5,726	\$ 1,963	\$ (3,763)	3425	\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 19,634	\$ 5,726	\$ 1,963	\$ (3,763)		\$	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 79,424	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 7,615	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 3,766	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (3,849)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,976	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: \$ **17,678** 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. /2008 \$ 346,020

13. /2009 \$ 346,020

14. /2010 \$ 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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 43,318	\$		\$ 43,318	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			15,561			15,561	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			91,379			91,379	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				126,040		126,040	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	medical supplies Other (specify): lab xray	39-2 39-3				32,974	31,657		64,631	13
14	TOTAL			\$		\$ 183,232	\$ 157,697		\$ 340,929	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 REHAB & CARE CENTER

0047100

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*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 97,293	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (25,000))	1,069,375		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	49,276		6
7	Other Prepaid Expenses	600		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Real Estate Escrow Deposit</u>	76,595		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,293,139	\$	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	19,369		15
16	Equipment, at Historical Cost	42,272		16
17	Accumulated Depreciation (book methods)	(32,891)		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>	10,110		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 38,860	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,331,999	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 553,033	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	411,607		29
30	Accrued Salaries Payable	58,768		30
31	Accrued Taxes Payable (excluding real estate taxes)	27,893		31
32	Accrued Real Estate Taxes(Sch.IX-B)	67,836		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,119,137	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,119,137	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 212,862	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,331,999	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 191,509	1
2	Restatements (describe):		2
3	ROUNDING	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 191,510	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	21,352	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 21,352	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 212,862	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	\$ 3,633,406	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,633,406	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	33,963	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 33,963	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,191	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,191	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Adj Prior Year Expense</u>	2,670	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,670	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,675,230	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	549,353	31
32	Health Care	1,404,687	32
33	General Administration	836,682	33
	B. Capital Expense		
34	Ownership	478,974	34
	C. Ancillary Expense		
35	Special Cost Centers	340,929	35
36	Provider Participation Fee	43,253	36
	D. Other Expenses (specify):		
37	<u>OUT-OF-PERIOD EXPENSES</u>		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,653,878	40
41	Income before Income Taxes (line 30 minus line 40)**	21,352	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 21,352	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 REHAB & CARE CENTER

0047100

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	1,551	1,738	\$ 60,295	\$ 34.69	1
2	Assistant Director of Nursing	1,374	1,545	37,593	24.33	2
3	Registered Nurses	10,561	12,083	284,088	23.51	3
4	Licensed Practical Nurses	6,873	8,081	189,950	23.51	4
5	CNAs & Orderlies	44,297	50,675	585,383	11.55	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,151	2,472	31,388	12.70	8
9	Activity Director	1,819	2,097	28,460	13.57	9
10	Activity Assistants	575	752	8,285	11.02	10
11	Social Service Workers	155	155	1,485	9.58	11
12	Dietician					12
13	Food Service Supervisor	1,863	2,140	36,195	16.91	13
14	Head Cook	6,110	6,920	66,691	9.64	14
15	Cook Helpers/Assistants	3,016	3,359	30,795	9.17	15
16	Dishwashers					16
17	Maintenance Workers	1,654	1,833	24,001	13.09	17
18	Housekeepers	8,081	9,327	97,229	10.42	18
19	Laundry	1,308	1,473	17,904	12.15	19
20	Administrator	1,748	2,080	84,946	40.84	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,867	2,271	46,066	20.28	23
24	Clerical	2,889	3,368	53,891	16.00	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	926	1,254	18,199	14.51	31
32	Other Health C: <u>MDS</u>	1,876	2,187	56,873	26.01	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	100,694	115,810	\$ 1,759,717 *	\$ 15.19	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	187	\$ 8,399	1-3	35
36	Medical Director	Monthly	9,900	9-3	36
37	Medical Records Consultant	19	1,215	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	Monthly	2,274	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	Monthly	4,090	11-3	44
45	Social Service Consultant	8	1,006	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	214	\$ 26,884		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				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
NANCY TETTEMER	ADMINISTRATOR	0	\$ 84,946	Workers' Compensation Insurance	\$ 61,033	IDPH License Fee	\$	
			0	Unemployment Compensation Insurance	39,214	Advertising: Employee Recruitment	7,885	
			0	FICA Taxes	134,255	Health Care Worker Background Check	1,872	
				Employee Health Insurance	24,346	(Indicate # of checks performed <u>117</u>)		
				Employee Meals	0	Patient Background Checks	120	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	0	
				EMPLOYEE BENEFITS - OTHER	6,050	MARKETING/ADV/PROMO	10,587	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	11,327	
				PENSION/PROFIT SHARING PLANS	4,823	MGMT CO ALLOC	511	
				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	(5,945)	
						Yellow page advertising	(4,642)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 84,946	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 269,721		\$ 23,515		
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			\$ 147,332			\$	Out-of-State Travel	\$
							In-State Travel	0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 147,332				Seminar Expense	2,183
							MGMT ALLOC	740
C. Professional Services							Entertainment Expense	
Vendor/Payee	Type		Amount				(
ACHIEVE HEALTHCARE	DATA PROCESSING		\$ 8,240				(
IVANS	DATA PROCESSING		328)	
KRUPNICK, BOKOR	ACCOUNTING		18,350				TOTAL (agree to Sch. V, line 24, col. 8)	
STRATTON, GIGANTI	LEGAL		66				\$ 2,923	
RICHARD PEELO & ASSOC	MEDICARE CONSULTANT		3,000					
SYSTEMATIC MANAGEMENT	MEDICARE B BILLING		2,134					
HEALTHCARE HORIZONS	MEDICAID CONSULTANT		9,200					
MARK GALLAUGHER			1,201					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 42,519	TOTAL			\$	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number **HILLSIDE REHAB & CARE CENTER**# **0047100**Report Period Beginning: **01/01/2007**Ending: **12/31/2007****XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. IL HEALTHCARE ASSOC \$5,135
- (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. \$ 54,313 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 _____ 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. \$ 43,253
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? 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