

		FOR BHF USE					

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2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2008)

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>0037572</u></p> <p>Facility Name: <u>HILLCREST HEALTHCARE CENTER</u></p> <p>Address: <u>777 DRAPER</u> <u>JOLIET</u> <u>60432</u> Number City Zip Code</p> <p>County: <u>WILL</u></p> <p>Telephone Number: <u>(847) 329-1555</u> Fax # <u>(847) 329-9555</u></p> <p>HFS ID Number: <u>36-3782789</u></p> <p>Date of Initial License for Current Owners: <u>09/15/91</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 checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input 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> Email Address: _____</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 checked="" type="checkbox"/> "Sub-S" Corp.			<input 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>01/01/2008</u> to <u>12/31/2008</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>SHERWIN I. RAY</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>PRESIDENT</u></td> </tr> <tr> <td rowspan="4" style="width: 15%;">Paid Preparer</td> <td>(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) _____</td> </tr> <tr> <td>(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></td> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> </tr> <tr> <td colspan="2"> <p>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> </td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>SHERWIN I. RAY</u> (Date) _____		(Title) <u>PRESIDENT</u>	Paid Preparer	(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) _____	(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>	<p>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>	
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Facility Name & ID Number HILLCREST HEALTHCARE CENTER

0037572 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	30,744	1
2		Skilled Pediatric (SNF/PED)			2
3	84	Intermediate (ICF)	84	30,744	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	168	TOTALS	168	61,488	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			1,290	1,290	8
9	SNF/PED					9
10	ICF	54,313	410		54,723	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	54,313	410	1,290	56,013	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.10%

D. How many bed-hold days during this year were paid by the Department? 1,172 (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 84 and days of care provided 1,290

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number **HILLCREST HEALTHCARE CENTER** # **0037572** Report Period Beginning: **01/01/2008** Ending: **12/31/2008**

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclassification 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	191,666	19,106	11,570	222,342		222,342		222,342		1
2	Food Purchase		235,584		235,584	(14,384)	221,200	(896)	220,304		2
3	Housekeeping	224,028	35,852		259,880		259,880		259,880		3
4	Laundry	27,067	14,814		41,881		41,881		41,881		4
5	Heat and Other Utilities			157,981	157,981		157,981	111	158,092		5
6	Maintenance	35,294	28,693	67,240	131,227		131,227	18,942	150,169		6
7	Other (specify):* SECURITY	75,343		20,124	95,467		95,467	46	95,513		7
8	TOTAL General Services	553,398	334,049	256,915	1,144,362	(14,384)	1,129,978	18,203	1,148,181		8
	B. Health Care and Programs										
9	Medical Director			21,600	21,600		21,600		21,600		9
10	Nursing and Medical Records	1,559,721	65,537	8,189	1,633,447		1,633,447	42,434	1,675,881		10
10a	Therapy	69,990	4,184	36,304	110,478		110,478	6,982	117,460		10a
11	Activities	97,638	43,162	12,117	152,917		152,917		152,917		11
12	Social Services	347,836			347,836		347,836		347,836		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,075,185	112,883	78,210	2,266,278		2,266,278	49,416	2,315,694		16
	C. General Administration										
17	Administrative	108,849		270,000	378,849		378,849	(132,949)	245,900		17
18	Directors Fees										18
19	Professional Services			314,751	314,751		314,751	(238,896)	75,855		19
20	Dues, Fees, Subscriptions & Promotions			22,247	22,247		22,247	(10,423)	11,824		20
21	Clerical & General Office Expenses	53,154	19,053	186,167	258,374		258,374	(26,286)	232,088		21
22	Employee Benefits & Payroll Taxes			398,369	398,369	14,384	412,753		412,753		22
23	Inservice Training & Education			4,157	4,157		4,157	2,496	6,653		23
24	Travel and Seminar			158	158		158	92	250		24
25	Other Admin. Staff Transportation			3,966	3,966		3,966	14,864	18,830		25
26	Insurance-Prop.Liab.Malpractice			83,948	83,948		83,948	2,867	86,815		26
27	Other (specify):*							64,743	64,743		27
28	TOTAL General Administration	162,003	19,053	1,283,763	1,464,819	14,384	1,479,203	(323,492)	1,155,711		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,790,586	465,985	1,618,888	4,875,459		4,875,459	(255,873)	4,619,586		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	9,248
	REPAIRS & MAINTENANCE	2,322
		0
		11,570
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	21,672
	ELECTRICITY	106,489
	WATER	29,820
	CABLE TV - LOBBY	0
		0
		157,981
6	MAINTENANCE	
	GROUNDS MAINTENANCE	11,900
	PAINTING & DECORATING	838
	BUILDING REPAIRS	4,840
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	21,552
	ELEVATOR MAINTENANCE & REPAIR	8,368
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	5,279
	FIRE SERVICE	14,463
		0
		0
		0
		0
		67,240
7	OTHER	
	SCAVENGER	20,124
	SECURITY SERVICE	0
		0
		0
		20,124
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	21,600
		21,600

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	2,756
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,317
	PHARMACY CONSULTANT XVIII B 39-2	2,016
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
	DENTAL SERVICES	2,100
		0
		8,189
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	435
	SPEECH THERAPY SERVICES	0
	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	25,069
		36,304
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	12,117
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		12,117
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
		0
		0
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	270,000
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	46,687
	ADMINISTRATIVE CONSULTANTS XIX C	228,000
	PROFESSIONAL FEES XIX C	40,064
		0
		314,751
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	13,485
	EMPLOYEE WANT ADS XIX F	5,874
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	240
	LICENSES & PERMITS XIX F	835
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	1,038
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	650
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	125
	PATIENT BACKGROUND CHECKS XIX F	0
		22,247
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,425
	EQUIPMENT REPAIR & MAINTENANCE	12,642
	OUTSIDE CLERICAL SERVICES	132,000
	PENALTIES / OVERDRAFT CHARGES VI 18	15,412
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	22,814
	MESSENGER SERVICE	1,874
		0
		186,167

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	210,655
	UNEMPLOYMENT COMPENSATION XIX D	37,622
	WORKERS COMPENSATION INSURANC XIX D	65,669
	HOSPITALIZATION INSURANCE XIX D	47,623
	EMPLOYEE BENEFITS - OTHER XIX D	36,670
	EMPLOYEE PHYSICAL EXAMS XIX D	130
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		398,369
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	4,157
		4,157
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	158
		158
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	3,966
		3,966
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	83,948
		83,948
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

1,618,888

**HILLCREST HEALTHCARE CENTER
SCHEDULES
12/31/2008**

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

TOTAL FOOD PURCHASE	235,584
LESS SALES TAX	(896)
NET FOOD	<u>234,688</u>
TOTAL PATIENT CENSUS	56,013
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	168,039
ADD # EMPLOYEE MEALS/DAY	30
TIME # DAYS	<u>366</u>
TOTAL EMPLOYEE MEALS	10,980
PATIENT MEALS	168,039
ADD EMPLOYEE MEALS	<u>10,980</u>
TOTAL MEALS/YEAR	179,019
NET FOOD	234,688
DIVIDE TOTAL MEALS/YEAR	<u>179,019</u>
COST PER MEAL	1.31
TIME EMPLOYEE MEALS	<u>10,980</u>
EMPLOYEE MEAL RECLASSIFICATION	<u>14,384</u>
	=====

**STAFF TRANSPORTATION
PAGE 3 LINE 25 COLUMN 3 OTHER**

AMY WALKO	3,966

TOTAL	<u>3,966</u>
	=====
GASOLINE FOR FACILITY BANKING, MAINTENANCE, MARKETING AND ACTIVITIES	

**PROFESSIONAL FEES
PAGE 21 SCHEDULE XIX PART C**

CAREPLUS MGT	DATA PROCESSING	31,272
ACHIEVE HEALTHCARE	DATA PROCESSING	3,203
AMERICAN DATA	DATA PROCESSING	4,063
NATIONAL DATA CARE	DATA PROCESSING	3,513
e-HEALTH DATA SOLUTIONS	DATA PROCESSING	3,805
ADAPTASOFT	DATA PROCESSING	403
EMDEON	DATA PROCESSING	428
CAREPLUS MGT	ADMINISTRATIVE CONSULTANT	228,000
KRUPNICK, BOKOR, KAGDA, LTD	ACCOUNTING	27,700
ABRAHAM A GUTNICKI ESQ	LEGAL	677
MEYER MAGENCE	LEGAL	5,378
PERSONNEL PLANNER	UC CONSULTANT	1,509
RICHARD PEELO	MEDICARE COST REPORT	4,800

**TOTAL PROFESSIONAL FEES
314,751
=====**

**EQUIPMENT RENTAL EXPENSE
PAGE 14 SCHEDULE XII PART B LINES 15**

UNIVERSAL HOSPITAL	NURSING EQUIPMENT	420
JOHNSON WATER CONDITION	PLANT EQUIPMENT	300
AIR CLEANING SPECIALISTS	SMOKEETERS	780
FAMILY PRIDE	WASHER/DRYER	9,000
GE CAPITAL	COPIER	7,525
STORAGE	STORAGE	745

**TOTAL EQUIPMENT RENTAL EXPENSE
18,770
=====**

**EDUCATION AND SEMINARS
PAGE 3 LINE 23 COLUMN 3 OTHER**

DATE	SPONSOR OF SEMINAR	SEMINAR PURPOSE	EMPLOYEE	LOC	COST
JAN	IL COUNCIL ON LONG TERM CARE	BE PREPARED FOR MDS MEDICAID AUDITS	AMY WALKO	IL	580
			MAUREEN PRESTLEGAARD		
			BRUCE SIMONSON		
			LYNN RINKE		
MAR	CROSS COUNTRY EDUCATION	ETHICAL PITFALLS: AVOIDING PROFESSIONAL HAZARDS	KRISTIN BELL	IL	169
MAR	HEARTLAND TRAINING CENTER	TRAIN THE TRAINERS	CARRIE THERRIEN	IL	400
APR	CMI EDUCATION INSTITUTE	OBESITY COMPULSIVE EATING AND BODY IMAGE	CARRIE THERRIEN	IL	149
MAY	PATHWAY HEALTH SERVICES	ACCIDENT PREVENTION PROGRAM TO MEET F323 GUIDELINES	AMY WALKO	IL	258
			MAUREEN PRESTEGAARD		
MAY	BARNES & NOBLE	DIALECTICAL BEHAVIOR THERAPY SKILL WORKBOOK		IL	18
MAY	CMI EDUCATION INSTITUTE	HOW THERAPISTS FAIL	CARRIE THERRIEN	IL	159
JUN	CLINICAL REIMBURSEMENT	MEDICARE WORKSHOP	JENNY SHAN-MARTIN	IL	594
JUN	PATHWAY HEALTH SERVICES	MARKETING 2008 A FOCUS ON CENSUS DEVELOPMENT & CENSUS RECOVERY	AMY ZUMPF	IL	129
JUN	CROSS COUNTRY EDUCATION	THE NEXT STEP: USING COGNITIVE-BEHAVIORAL THERAPY TO IDENTIFY AND CORRECT HIGHLY IRRATIONAL THOUGHTS	KRISTIN BELL	IL	159
JUN	SAFE FOOD HANDLERS CORP	2008 ILLINOIS FOOD SERVICE SANITATION COURSE	2 EMPLOYEES	IL	330
AUG	MEDS-PDN	SKIN & WOUND CARE MANAGEMENT	AMY WALKO	IL	198
SEP	IMHCA			IL	120
SEP	CAREPLUS MANAGEMENT			IL	215
SEP	ILLINOIS COUNCIL ON LONG TERM CARE			IL	380
OCT	PESI	THE TEN BEST-EVER ANXIETY TREATMENT TECHNIQUES	KRISTIN BELL	IL	184
NOV	HCPRO			IL	116

			TOTAL		4158
					=====

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

#0037572

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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			67,024	67,024		67,024	178,045	245,069			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			14,467	14,467		14,467	491,849	506,316			32
33	Real Estate Taxes			71,379	71,379		71,379	9,365	80,744			33
34	Rent-Facility & Grounds			606,229	606,229		606,229	(606,229)				34
35	Rent-Equipment & Vehicles			24,947	24,947		24,947	10,356	35,303			35
36	Other (specify):* OFFICE RENT			24,000	24,000		24,000	(24,000)				36
37	TOTAL Ownership			808,046	808,046		808,046	59,386	867,432			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		62,533	65,455	127,988		127,988		127,988			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			92,232	92,232		92,232		92,232			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		62,533	157,687	220,220		220,220		220,220			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,790,586	528,518	2,584,621	5,903,725		5,903,725	(196,487)	5,707,238			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	(7,235)	30		9
10	Interest and Other Investment Income	(11,953)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(896)	2		13
14	Non-Care Related Interest	(12,068)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(650)	20		17
18	Fines and Penalties	(15,412)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(13,485)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,038)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (62,737)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	(133,750)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (133,750)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (196,487)		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ID# 0037572

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

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:

01/01/2008

Ending:

12/31/2008

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	(896)	0	0	0	0	0	0	0	0	0	0	(896)	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	111	0	0	0	0	0	0	0	0	0	111	5
6	Maintenance	0	18,942	0	0	0	0	0	0	0	0	0	18,942	6
7	Other (specify):*	0	46	0	0	0	0	0	0	0	0	0	46	7
8	TOTAL General Services	(896)	19,099	0	0	0	0	0	0	0	0	0	18,203	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	42,434	0	0	0	0	0	0	0	0	0	42,434	10
10a	Therapy	0	6,982	0	0	0	0	0	0	0	0	0	6,982	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	49,416	0	0	0	0	0	0	0	0	0	49,416	16
	C. General Administration													
17	Administrative	0	(132,949)	0	0	0	0	0	0	0	0	0	(132,949)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(238,896)	0	0	0	0	0	0	0	0	0	(238,896)	19
20	Fees, Subscriptions & Promotions	(15,173)	4,750	0	0	0	0	0	0	0	0	0	(10,423)	20
21	Clerical & General Office Expenses	(15,412)	(132,000)	121,126	0	0	0	0	0	0	0	0	(26,286)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	2,496	0	0	0	0	0	0	0	0	2,496	23
24	Travel and Seminar	0	0	92	0	0	0	0	0	0	0	0	92	24
25	Other Admin. Staff Transportation	0	0	14,864	0	0	0	0	0	0	0	0	14,864	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,867	0	0	0	0	0	0	0	0	2,867	26
27	Other (specify):*	0	0	64,743	0	0	0	0	0	0	0	0	64,743	27
28	TOTAL General Administration	(30,585)	(499,095)	206,188	0	(323,492)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(31,481)	(430,580)	206,188	0	(255,873)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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 (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	(7,235)	0	16,093	169,187	0	0	0	0	0	0	0	178,045	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(24,021)	0	55,839	460,031	0	0	0	0	0	0	0	491,849	32
33	Real Estate Taxes	0	0	9,365	0	0	0	0	0	0	0	0	9,365	33
34	Rent-Facility & Grounds	0	0	0	(606,229)	0	0	0	0	0	0	0	(606,229)	34
35	Rent-Equipment & Vehicles	0	0	10,356	0	0	0	0	0	0	0	0	10,356	35
36	Other (specify):*	0	(24,000)	0	0	0	0	0	0	0	0	0	(24,000)	36
37	TOTAL Ownership	(31,256)	(24,000)	91,653	22,989	0	59,386	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)	(62,737)	(454,580)	297,841	22,989	0	(196,487)	45						

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				CAREPLUS MGMT	SKOKIE	MGMT/CLERICAL
				CAREPLUS REHABILITATIVE SERVICES		
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	36	OFFICE RENT	24,000	" "			(24,000)	5
6	V	5	UTILITIES		" "		111	111	6
7	V	6	MAINTENANCE		" "		18,942	18,942	7
8	V	7	SECURITY		" "		46	46	8
9	V	10	NURSING		" "		42,434	42,434	9
10	V	10a	THERAPY		" "		6,982	6,982	10
11	V	17	ADMIN		" "		137,051	137,051	11
12	V	19	PROFESSIONAL FEES		" "		20,376	20,376	12
13	V	20	DUES/LICENSES/WANT ADS		" "		4,750	4,750	13
14	Total		\$ 685,272			\$ 230,692	\$ *	(454,580)	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	21 OFFICE	\$	CAREPLUS MGMT INC		\$ 121,126	\$ 121,126
16	V	23 SEMINARS		" "		2,496	2,496
17	V	24 IN-STATE TRAVEL/LODGING		" "		92	92
18	V	25 TRANSPORTATION		" "		14,864	14,864
19	V	26 INSURANCE		" "		2,867	2,867
20	V	27 EMPLOYEE BENEFITS		" "		64,743	64,743
21	V	30 SL DEPRECIATION		" "		11,126	11,126
22	V	32 INTEREST		" "		54,696	54,696
23	V	33 REAL ESTATE TAX		" "		9,365	9,365
24	V	35 EQUIPMENT RENT		" "		10,356	10,356
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V	30 SL DEPRECIATION		CAREPLUS REHABILITATIVE SERVICES		4,967	4,967
36	V	32 INTEREST		" "		1,143	1,143
37	V						
38	V						
39	Total		\$			\$ 297,841	\$ * 297,841

* 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	\$ 606,229	HILLCREST REALTY LLC		\$	\$ (606,229)
16	V	30 SL DEPRECIATION		" "		169,187	169,187
17	V	32 INTEREST		" "		450,458	450,458
18	V	32 AMORT LOAN COST		" "		9,573	9,573
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		\$ 606,229			\$ 629,218	\$ * 22,989

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

Facility Name & ID Number HILLCREST HEALTHCARE CENTER # 0037572 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	CAREPLUS MGMT ALLOCATIONS:									
2	SHERWIN RAY	PRESIDENT	ADMIN/FINANCE	SEE ATTACHED	9	14.98	SALARY	29,212	17-7	2
3	JAKOB BAKST	DIR OPERATIONS	ADMIN/CONS.	SCHEDULES	9	14.98	" "	29,212	17-7	3
4	ROSLYN INDICH	EXECUTIVE ASST	A/P MGMT	" "	9	14.98	" "	9,106	17-7	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13							TOTAL	\$ 67,530		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:

01/01/2008

Ending: 2/31/2008

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	5	UTILITIES	373,906	10 FACILITIES	\$ 739	\$	56,013	\$ 111	1
2	6	MAINTENANCE	373,906	10 FACILITIES	126,444	52,396	56,013	18,942	2
3	7	SECURITY	373,906	10 FACILITIES	308		56,013	46	3
4	10	NURSING	373,906	10 FACILITIES	283,260	283,260	56,013	42,434	4
5	10a	THERAPY	373,906	10 FACILITIES	46,604	46,472	56,013	6,982	5
6	17	ADMIN SALARIES	373,906	10 FACILITIES	914,862	914,862	56,013	137,051	6
7	19	PROFESSIONAL FEES	373,906	10 FACILITIES	136,016		56,013	20,376	7
8	20	DUES/LICENSES/WANT ADS	373,906	10 FACILITIES	31,710		56,013	4,750	8
9	21	OFFICE EXPENSES	373,906	10 FACILITIES	808,558	628,409	56,013	121,126	9
10	23	SEMINARS	373,906	10 FACILITIES	16,659		56,013	2,496	10
11	24	TRAVEL	373,906	10 FACILITIES	612		56,013	92	11
12	25	TRANSPORTATION	373,906	10 FACILITIES	99,225		56,013	14,864	12
13	26	INSURANCE	373,906	10 FACILITIES	19,140		56,013	2,867	13
14	27	EMPLOYEE BENEFITS	373,906	10 FACILITIES	432,184		56,013	64,743	14
15	30	SL DEPRECIATION	373,906	10 FACILITIES	74,261		56,013	11,126	15
16	32	INTEREST-TAG MTG/LOC/EQ LOAN	373,906	10 FACILITIES	365,115		56,013	54,696	16
17	33	REAL ESTATE TAX	373,906	10 FACILITIES	62,515		56,013	9,365	17
18	35	EQUIP RENT/AUTO LEASE	373,906	10 FACILITIES	69,127		56,013	10,356	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,487,339	\$ 1,925,399		\$ 522,423	25

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

0037572

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense
		YES	NO				Original	Balance			
A. Directly Facility Related											
Long-Term											
1	RELATED PARTY: HILLCREST REALTY LLC						\$	\$			\$
2	LAKE FOREST BK		X	MORTGAGE	\$50,519.11	02/07	6,400,000	6,111,385	02/22/12	7.1500	450,458
3	LOAN COSTS		X	LOAN COSTS	W/O OVER LOAN	02/07	47,863	29,914	02/22/12		9,573
4											
5	FOX VALLEY FIRE		X	SPRINKLER SYSTEM LOAN	\$6,855.43	09/08	78,809	53,234	09/09	8.0000	1,847
Working Capital											
6	INSURANCE FINANCING		X	INSUR. FINANCE							552
7	CAREPLUS MGMT ALLOCATION: TAG MTG INT/LOC/EQ LOAN										54,696
8	CAREPLUS REHAB ALLOCATION: EQUIP LOAN										1,143
9	TOTAL Facility Related				\$57,374.54		\$ 6,526,672	\$ 6,194,533			\$ 518,269
B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES							12,068
11											
12											
13											
14	TOTAL Non-Facility Related						\$	\$			\$ 12,068
15	TOTALS (line 9+line14)						\$ 6,526,672	\$ 6,194,533			\$ 530,337

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 2007 report.	\$	72,450	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.)	\$	71,559	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(891)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	72,270	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.	\$	71,379	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	71,328	8
	2004	73,735	9
	2005	73,897	10
	2006	71,733	11
	2007	71,559	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	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 2007 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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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>71,558.56</u>	\$ <u>71,558.56</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>71,558.56</u>	\$ <u>71,558.56</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

01/01/2008 Ending:

12/31/2008

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	TOTALS	<u>132,928</u>		\$ <u>336,000</u>	<u>3</u>

Facility Name & ID Number HILLCREST HEALTHCARE CENTER

0037572

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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	RELATED PARTY: HILLCREST REALTY LLC:			\$	\$		\$	\$	\$	4
5	168	2007		5,288,123	135,587	27.5	135,587		220,461	5
6										6
7										7
8										8
	Improvement Type**									
9	LEASEHOLD IMPROVEMENTS		1991	6,230	198	31.5	198		3,400	9
10	LEASEHOLD IMPROVEMENTS		1992	48,072	1,525	31.5	1,526	1	25,179	10
11	LEASEHOLD IMPROVEMENTS		1993	33,291	981	31.5	1,057	76	16,383	11
12	LEASEHOLD IMPROVEMENTS		1994	10,172	261	39	261		3,752	12
13	ROOF REPAIR		1995	5,221	134	39	134		1,781	13
14	CONDENSING UNITS		1996	3,924	101	39	101		1,275	14
15	CEILING TILES		1996	1,334	34	39	34		424	15
16	ROOF REPAIR		1996	8,079	207	39	207		2,562	16
17	DOORS		1997	1,078	28	39	28		323	17
18	WINDOWS & ROOF VENTILATOR		1997	3,572	92	39	92		1,016	18
19	WINDOWS		1998	12,100	309	39	310	1	3,287	19
20	ROOF REPAIRS/DOORS/ELEC. REPAIRS/LOT LIGHTS		1998	23,693	607	39	607		6,410	20
21	WALLCOVER/RAILS/NURSE STNS/WINDOW TREATMENTS		1998	155,436	3,985	39	3,985		41,747	21
22	WINDOWS/DECORATING/CEILING TILE/ROOF REPAIR		1999	70,751	1,814	39	1,814		17,278	22
23	WINDOWS/FLOORING/DOOR		2000	12,169	442	27.5	442		3,818	23
24	CARPETING		2000	2,088		10	209	209	1,776	24
25	DOORS/ELEVATOR REPAIRS/SECURITY SYSTEM UPGRADE		2001	42,268	1,536	27.5	1,537	1	11,864	25
26	FENCE		2001	10,361	691	15	691		5,182	26
27	ROOF REPAIRS/CEILING TILE/FIRE DAMPERS/LIGHTING		2001	43,148	1,568	27.5	1,569	1	11,286	27
28	ROOF REPAIRS/HEAT/AC REPAIRS		2002	12,346	450	27.5	449	(1)	2,877	28
29	FENCE		2002	4,573	305	15	305		1,982	29
30	DOOR REPLACEMENTS/DUCTWORK-FIRE CODE		2003	7,297	266	27.5	265	(1)	1,504	30
31	DURO-LAST ROOF SYSTEM		2003	66,500	3,355	27.5	3,355		17,661	31
32	WALL A/C UNIT INSTALLATIONS / ELEVATOR BUTTONS		2003	92,265	2,418	27.5	2,418		12,997	32
33	FENCE / PARKING LOT SEAL		2003	8,816	588	15	588		3,234	33
34	EXTERIOR DOORS		2004	2,807	102	27.5	102		472	34
35	BATHROOM REMODELING		2004	2,500	91	27.5	91		413	35
36	SPRINKLERS/PIPING		2004	1,881	68	27.5	68		303	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number HILLCREST HEALTHCARE CENTER

0037572

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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		\$ 991	37
38	BATHROOMS/KITCHEN REMODELING	2005	51,970	1,890	27.5	1,890		6,689	38
39	FIRE ALARM SYSTEM	2005	61,833	2,248	27.5	2,248		8,196	39
40	DOORS	2006	7,026	256	27.5	255	(1)	712	40
41	WALL A/C UNITS / SMOKE ROOM EXHAUST / TILE	2006	29,088	1,057	27.5	1,058	1	2,633	41
42	WALL A/C /DOORS/LOCKERS/GUTTERS/ELECTRICAL	2007	45,233	1,645	27.5	1,645		2,664	42
43	CEDAR FENCE	2007	9,600	640	15	640		960	43
44	DEMOLITION/FRAMING/INSULATION/DRYWALL/WALL TILE/FLOOR TILE/BASEBOARDS/PLUMBING/ELECTRICAL/TOILETS/SINKS/FIXTURES/CABINETS/CEILINGS/								44
45	WALL PREP/PAINTING/CARPETING	2008	136,414	4,341	27.5	4,341		4,341	45
46	ELEVATOR/DOORS/AC/DUCTWORK/SPRINKLER SYST	2008	238,390	3,104	27.5	3,104		3,104	46
47	BLACKTOP/SIDEWALK/PATIO/CONCRETE BENCHES	2008	20,200	673	15	673		673	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		3,622	57
58	CEILINGS/DRYWALL	2004	6,913	178	39	178		856	58
59	FIRE DAMPERS/DUCTWORK	2004	10,058	258	39	258		1,138	59
60									60
61									61
62	RELATED PARTY ALLOCATION - CAREPLUS MGMT								62
63	BUILDING-TAG-18 PROPERTIES	2004	58,244	2,343	39	2,343		7,440	63
64	BUILDING IMPROVEMENTS-TAG-18 PROPERTIES	2004	22,882	1,772	39	1,772		4,787	64
65	BUILDING IMPROVEMENTS-CAREPLUS MGMT	2007		10	39	10			65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,714,484	\$ 179,171		\$ 179,458	\$ 287	\$ 469,453	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	\$ 227,140	\$ 17,276	\$ 18,101	\$ 825	8-15 YRS	\$ 133,180	71
72	Current Year Purchases	17,278	9,692	804	(8,888)	8-15 YRS	804	72
73	Fully Depreciated Assets		44,376	44,376				73
74	**REL'D PARTY-SL DEPN:CAREPL MGT, 7,001 /CP REHAB, 3,775 /HILLCREST LLC, 33,600							
75	TOTALS	\$ 244,418	\$ 71,344	\$ 63,281	\$ (8,063)		\$ 133,984	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY VAN	'02 DODGE RAM BR150	2006	\$ 9,319	\$ 1,789	\$ 2,330	\$ 541	4 YRS	\$ 5,825	76
77										77
78										78
79										79
80	TOTALS			\$ 9,319	\$ 1,789	\$ 2,330	\$ 541		\$ 5,825	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)	\$ 7,304,221	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 252,304	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 245,069	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (7,235)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 609,262	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: N/A - 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:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			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: \$ 18,770 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>ACTIVITY/HSKP/</u>		\$ <u>686.33</u>	\$ <u>6,177</u>	17
18	<u>MAINT/BANKING/</u>				18
19	<u>ADMIN/ETC</u>				19
20					20
21	TOTAL		\$ <u>686.33</u>	\$ <u>6,177</u>	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2009 \$ _____

13. _____ /2010 \$ _____

14. _____ /2011 \$ _____

* 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	\$		\$ 9,695	\$		\$ 9,695	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			120			120	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			55,640			55,640	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				60,741		60,741	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	MED.SUPPLIES/LAB/RENTALS Other (specify):	39-2					1,792		1,792	13
14	TOTAL			\$		\$ 65,455	\$ 62,533		\$ 127,988	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number HILLCREST HEALTHCARE CENTER

0037572

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(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	\$ 498	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 110,000)	3,382,701		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	408,441		5
6	Prepaid Insurance	87,091		6
7	Other Prepaid Expenses	2,710		7
8	Accounts Receivable (owners or related parties)	25,000		8
9	Other(specify): R.E.TAX ESCROW	32,961		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,939,402	\$	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	1,298,799		15
16	Equipment, at Historical Cost	253,737		16
17	Accumulated Depreciation (book methods)	(449,565)		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	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,120,231	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,059,633	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 803,131	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	836		28
29	Short-Term Notes Payable	53,234		29
30	Accrued Salaries Payable	207,036		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,106		31
32	Accrued Real Estate Taxes(Sch.IX-B)	72,270		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)	\$ 1,153,613	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	290,148		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	DUE TO LLC	424,562		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 714,710	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,868,323	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 3,191,310	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,059,633	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,203,379	1
2	Restatements (describe):		2
3	IL REPLACEMENT TAX	(3,004)	3
4	ROUNDING	9	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,200,384	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	990,926	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)	\$ 990,926	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)	\$ 3,191,310	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,882,698	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,882,698	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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***	11,953	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11,953	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,894,651	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,144,362	31
32	Health Care	2,266,278	32
33	General Administration	1,464,819	33
	B. Capital Expense		
34	Ownership	808,046	34
	C. Ancillary Expense		
35	Special Cost Centers	127,988	35
36	Provider Participation Fee	92,232	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,903,725	40
41	Income before Income Taxes (line 30 minus line 40)**	990,926	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 990,926	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: 01/01/2008

Ending: 12/31/2008

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	1,515	2,206	\$ 76,064	\$ 34.48	1
2	Assistant Director of Nursing	1,598	2,145	64,481	30.06	2
3	Registered Nurses	9,549	10,427	276,726	26.54	3
4	Licensed Practical Nurses	23,336	24,642	576,862	23.41	4
5	CNAs & Orderlies	38,132	42,403	408,770	9.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,477	6,493	69,990	10.78	8
9	Activity Director	2,044	2,281	37,928	16.63	9
10	Activity Assistants	6,393	7,344	59,710	8.13	10
11	Social Service Workers	19,658	21,021	347,836	16.55	11
12	Dietician					12
13	Food Service Supervisor	1,885	2,109	40,613	19.26	13
14	Head Cook	6,996	7,461	61,701	8.27	14
15	Cook Helpers/Assistants	10,390	11,368	89,352	7.86	15
16	Dishwashers					16
17	Maintenance Workers	2,067	2,281	35,294	15.47	17
18	Housekeepers	24,486	26,942	224,028	8.32	18
19	Laundry	2,793	3,140	27,067	8.62	19
20	Administrator	2,089	2,199	85,356	38.82	20
21	Assistant Administrator	979	1,025	23,493	22.92	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,049	4,315	53,154	12.32	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	2,077	2,295	24,347	10.61	31
32	Other Health C: <u>MDS/CPC</u>	4,124	4,576	132,471	28.95	32
33	Other(specify) <u>SECURITY</u>	8,533	9,132	75,343	8.25	33
34	TOTAL (lines 1 - 33)	178,170	195,805	\$ 2,790,586 *	\$ 14.25	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	\$ 9,248	1-3	35
36	Medical Director	O	21,600	9-3	36
37	Medical Records Consultant	N	1,317	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)		\$ 44,981		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
AMY E WALKO	ADMINISTRATOR		\$ 85,356	Workers' Compensation Insurance	\$ 65,669	IDPH License Fee	\$	
MELISSA A HOUSER	ASST ADMIN		23,493	Unemployment Compensation Insurance	37,622	Advertising: Employee Recruitment	5,874	
				FICA Taxes	210,655	Health Care Worker Background Check	125	
				Employee Health Insurance	47,623	(Indicate # of checks performed <u>127</u>)		
				Employee Meals	14,384	Patient Background Checks	79	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	650	
				EMPLOYEE BENEFITS - OTHER	36,670	MARKETING/ADV/PROMO	14,523	
				EMPLOYEE PHYSICAL EXAMS	130	LICENSES/DUES/SUBSCRIPTIONS	1,075	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOC	4,750	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(650)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(13,485)	
						Yellow page advertising	(1,038)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 108,849	TOTAL (agree to Schedule V, line 22, col.8)	\$ 412,753	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 11,824	
B. Administrative - Other			E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount
CAREPLUS MGMT	MANAGEMENT FEES		\$ 270,000				Out-of-State Travel	\$
							In-State Travel	
							TRAVEL & LODGING	158
							MGMT CO ALLOCATION	92
							(IL LODGING BETW FACIL & MGT CO)	
							Seminar Expense	0
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 270,000	TOTAL		\$	TOTAL	\$ 250
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$					
SEE SCHEDULE ATTACHED			314,751					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 314,751					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number HILLCREST HEALTHCARE CENTER# 0037572Report Period Beginning: 01/01/2008Ending: 12/31/2008**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. \$ 901 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. \$ 92,232
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. \$ 14,384 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