

Facility Name & ID Number HILLSIDE REHABILITATION & CARE CENTER

0047100 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	<u>58</u>	Skilled (SNF)	<u>58</u>	<u>21,228</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>21</u>	Intermediate (ICF)	<u>21</u>	<u>7,686</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>28,914</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>11</u>	<u>160</u>	<u>2,445</u>	<u>2,616</u>	8
9	SNF/PED					9
10	ICF	<u>11,571</u>	<u>8,621</u>		<u>20,192</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>11,582</u>	<u>8,781</u>	<u>2,445</u>	<u>22,808</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.88%

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 4/01/05

J. Was the facility purchased or leased after January 1, 1978?
YES Date 4/01/05 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 79 and days of care provided 2,445

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL 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 **HILLSIDE REHABILITATION & CARE CI** # **0047100** 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				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	133,431	11,484	7,437	152,352		152,352		152,352		1
2	Food Purchase		102,214		102,214		102,214	(61)	102,153		2
3	Housekeeping	83,994	9,307		93,301		93,301		93,301		3
4	Laundry	29,412	8,291	25,549	63,252		63,252		63,252		4
5	Heat and Other Utilities			70,523	70,523		70,523	1,160	71,683		5
6	Maintenance	29,910	7,499	42,287	79,696		79,696	5,779	85,475		6
7	Other (specify):*			12,345	12,345		12,345	199	12,544		7
8	TOTAL General Services	276,747	138,795	158,141	573,683		573,683	7,077	580,760		8
	B. Health Care and Programs										
9	Medical Director			11,050	11,050		11,050		11,050		9
10	Nursing and Medical Records	1,210,102	114,546	25,038	1,349,686		1,349,686		1,349,686		10
10a	Therapy	37,913	248		38,161		38,161		38,161		10a
11	Activities	37,877	3,518		41,395		41,395		41,395		11
12	Social Services	6,715		1,023	7,738		7,738		7,738		12
13	CNA Training										13
14	Program Transportation			5,509	5,509		5,509		5,509		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,292,607	118,312	42,620	1,453,539		1,453,539		1,453,539		16
	C. General Administration										
17	Administrative	95,633		149,911	245,544		245,544	(72,161)	173,383		17
18	Directors Fees										18
19	Professional Services			62,186	62,186		62,186	(13,848)	48,338		19
20	Dues, Fees, Subscriptions & Promotions			30,623	30,623		30,623	(13,103)	17,520		20
21	Clerical & General Office Expenses	97,444	12,122	86,338	195,904		195,904	(57,054)	138,850		21
22	Employee Benefits & Payroll Taxes			233,219	233,219		233,219		233,219		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,484	3,484		3,484	737	4,221		24
25	Other Admin. Staff Transportation			3,648	3,648		3,648	1,967	5,615		25
26	Insurance-Prop.Liab.Malpractice			46,388	46,388		46,388	1,817	48,205		26
27	Other (specify):*			184,017	184,017		184,017	(165,545)	18,472		27
28	TOTAL General Administration	193,077	12,122	799,814	1,005,013		1,005,013	(317,190)	687,823		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,762,431	269,229	1,000,575	3,032,235		3,032,235	(310,113)	2,722,122		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	7,437
	REPAIRS & MAINTENANCE	0
		0
		7,437
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	577
	CONTRACTED SERVICES	24,972
		25,549
5	HEAT & OTHER UTILITIES	
	GAS HEAT	1,950
	ELECTRICITY	55,760
	WATER	7,127
	CABLE TV - LOBBY	5,686
		0
		70,523
6	MAINTENANCE	
	GROUNDS MAINTENANCE	7,563
	PAINTING & DECORATING	1,364
	BUILDING REPAIRS	18,433
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	6,481
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	2,215
	FIRE SERVICE	6,231
		0
		0
		0
		0
		42,287
7	OTHER	
	SCAVENGER	12,345
	SECURITY SERVICE	0
		0
		0
		12,345
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	11,050
		11,050

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	17,305
	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	1,245
	PHARMACY CONSULTANT XVIII B 39-2	1,860
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
	RESPIRATORY	338
	PROGRAM CONSULTANT	4,290
		25,038
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	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	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	1,023
		0
		1,023
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	5,509
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	149,911
18	DIRECTORS FEES	
	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	10,174
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	52,012
		0
		62,186
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	7,728
	EMPLOYEE WANT ADS XIX F	6,174
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	7,361
	LICENSES & PERMITS XIX F	1,085
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	5,408
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	348
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	951
	PATIENT BACKGROUND CHECKS XIX F	1,568
		30,623
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	7,979
	EQUIPMENT REPAIR & MAINTENANCE	1,694
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	539
	HOME OFFICE EXPENSE	60,000
	THEFT & DAMAGE LOSS	0
	TELEPHONE	16,126
	MESSENGER SERVICE	0
		0
		86,338

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	133,647
	UNEMPLOYMENT COMPENSATION XIX D	13,209
	WORKERS COMPENSATION INSURANC XIX D	55,824
	HOSPITALIZATION INSURANCE XIX D	19,262
	EMPLOYEE BENEFITS - OTHER XIX D	5,864
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	5,413
	CHICAGO HEAD TAX XIX D	0
		0
		233,219
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	3,484
	TRAVEL XIX G	
		3,484
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	3,648
		3,648
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	46,388
		46,388
27	OTHER	
	BAD DEBTS VI 24	184,017
		184,017

GRAND TOTAL COLUMN 3 OTHER

1,000,575

HILLSIDE REHABILITATION & CARE CENTER
SCHEDULES
12/31/2008

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

TOTAL FOOD PURCHASE	102,214
LESS SALES TAX	<u>(61)</u>
NET FOOD	102,153

TOTAL PATIENT CENSUS	22,808
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	68,424

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>366</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	68,424
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	68,424

NET FOOD	102,153
DIVIDE TOTAL MEALS/YEAR	<u>68,424</u>

COST PER MEAL	1.49
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			4,521	4,521		4,521	(633)	3,888		30
31	Amortization of Pre-Op. & Org.			1,827	1,827		1,827		1,827		31
32	Interest			27,052	27,052		27,052	(1,033)	26,019		32
33	Real Estate Taxes			83,471	83,471		83,471	948	84,419		33
34	Rent-Facility & Grounds			352,882	352,882		352,882		352,882		34
35	Rent-Equipment & Vehicles			14,798	14,798		14,798		14,798		35
36	Other (specify):*										36
37	TOTAL Ownership			484,551	484,551		484,551	(718)	483,833		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		105,808	194,111	299,919		299,919		299,919		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			43,372	43,372		43,372		43,372		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		105,808	237,483	343,291		343,291		343,291		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,762,431	375,037	1,722,609	3,860,077		3,860,077	(310,831)	3,549,246		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	(1,466)	30		9
10	Interest and Other Investment Income	(3,119)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(61)	2		13
14	Non-Care Related Interest		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	(539)	21		18
19	Entertainment		20		19
20	Contributions	(348)	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	(184,017)	27		24
25	Fund Raising, Advertising and Promotional	(7,728)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(5,408)	20		28
29	Other-Attach Schedule	(38,193)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (240,879)		\$	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)	(69,952)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (69,952)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (310,831)		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

STATE OF ILLINOIS
HILLSIDE REHABILITATION & CARE CENTER

ID# 0047100

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 0	6	1
2				2
3	MARKETING SALARY	(22,010)	21	3
4	PROF. FEES. - MARKETING	(7,183)	19	4
5	PROF. FEES - HEALTHCARE HORIZONS	(9,000)	19	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	(38,193)		49

STATE OF ILLINOIS

Summary A

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

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	(61)	0	0	0	0	0	0	0	0	0	0	(61)	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	1,160	0	0	0	0	0	0	0	0	0	1,160	5
6	Maintenance	0	5,779	0	0	0	0	0	0	0	0	0	5,779	6
7	Other (specify):*	0	199	0	0	0	0	0	0	0	0	0	199	7
8	TOTAL General Services	(61)	7,138	0	7,077	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	(72,161)	0	0	0	0	0	0	0	0	0	(72,161)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(16,183)	2,335	0	0	0	0	0	0	0	0	0	(13,848)	19
20	Fees, Subscriptions & Promotions	(13,484)	381	0	0	0	0	0	0	0	0	0	(13,103)	20
21	Clerical & General Office Expenses	(22,549)	(34,505)	0	0	0	0	0	0	0	0	0	(57,054)	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	737	0	0	0	0	0	0	0	0	0	737	24
25	Other Admin. Staff Transportation	0	1,967	0	0	0	0	0	0	0	0	0	1,967	25
26	Insurance-Prop.Liab.Malpractice	0	1,817	0	0	0	0	0	0	0	0	0	1,817	26
27	Other (specify):*	(184,017)	18,472	0	0	0	0	0	0	0	0	0	(165,545)	27
28	TOTAL General Administration	(236,233)	(80,957)	0	(317,190)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(236,294)	(73,819)	0	(310,113)	29								

STATE OF ILLINOIS

Summary B

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

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(1,466)	0	833	0	0	0	0	0	0	0	0	(633)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,119)	0	2,086	0	0	0	0	0	0	0	0	(1,033)	32
33	Real Estate Taxes	0	0	948	0	0	0	0	0	0	0	0	948	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	(4,585)	0	3,867	0	(718)	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)	(240,879)	(73,819)	3,867	0	(310,831)	45							

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
WILLIAM IRVINE	50			HI CARE MANAGEMENT	SPRINGFIELD	MANAGEMENT
ROBERT HEDGES	50	SEE ATTACHED SCHEDULE		HEALTHCARE HORIZONS	SPRINGFIELD	NURSING 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	\$ 149,911	HI CARE MANAGEMENT				(149,911)	1
2	V	21 HOME OFFICE EXPENSE	60,000	" " "				(60,000)	2
3	V	5 UTILITIES		" " "		1,160		1,160	3
4	V	6 MAINTENANCE		" " "		5,779		5,779	4
5	V	7 SCAVENGER & EXTERM		" " "		199		199	5
6	V	17 ADMINISTRATIVE		" " "		77,750		77,750	6
7	V	19 PROFESSIONAL FEES		" " "		2,335		2,335	7
8	V	20 DUES & SUBSCRIPTION		" " "		381		381	8
9	V	21 OFFICE EXPENSE		" " "		25,495		25,495	9
10	V	24 TRAVEL & SEMINARS		" " "		737		737	10
11	V	25 TRANSPORTATION		" " "		1,967		1,967	11
12	V	26 INSURANCE		" " "		1,817		1,817	12
13	V	27 PAYROLL TAXES & GRP INS		" " "		18,472		18,472	13
14	Total		\$ 209,911			\$ 136,092	\$ *	(73,819)	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		" " " "		2,086	2,086	16
17	V	33 REAL ESTATE TAXES		" " " "		948	948	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		\$			\$ 3,867	\$ * 3,867	39

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

Facility Name & ID Number **HILLSIDE REHABILITATION & CARE C** # **0047100** Report Period Beginning: **01/01/2008** 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ROBERT HEDGES	PRESIDENT	OFFICE MGMT.	50.00				SALARY	\$ 24,382	17-7	1
2											2
3											3
4	WILLIAM IRVINE	VICE PRESIDENT	OFFICE MGMT.	50.00				SALARY	24,382	17-7	4
5											5
6							SEE				6
7	MARTHA IRVINE	BOOKKEEPING					ATTACHED	SALARY	1,806	17-7	7
8							SCHEDULE				8
9											9
10	DEREK HEDGES	SPECIAL PROJECTS MNGR						SALARY	9,551	17-7	10
11											11
12											12
13								TOTAL	\$ 60,121		13

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

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

Facility Name & ID Number HILLSIDE REHABILITATION & CARE CENTER # 0047100 Report Period Beginning: 01/01/2008 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 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	182,408	7	\$ 9,275	22,808	\$ 1,160	1	
2	6	MAINTENANCE	PER RESIDENT DAY	182,408	7	46,214	38,650	22,808	5,779	2
3	7	SCAVENGER & EXTERMIN.	PER RESIDENT DAY	182,408	7	1,592	22,808		199	3
4	17	OFFICER SALARY	PER RESIDENT DAY	182,408	7	195,000	195,000	22,808	24,382	4
5	17	OFFICER SALARY	PER RESIDENT DAY	182,408	7	195,000	195,000	22,808	24,382	5
6	17	DIRECTOR OF OPERATIONS	PER RESIDENT DAY	182,408	7	71,673	71,673	22,808	8,962	6
7	17	DIRECTOR OF FINANCE	PER RESIDENT DAY	182,408	7	83,756	83,756	22,808	10,473	7
8	17	SPECIAL PROJ MNGR	PER RESIDENT DAY	182,408	7	76,385	76,385	22,808	9,551	8
9	19	PROFESSIONAL FEES	PER RESIDENT DAY	182,408	7	18,671		22,808	2,335	9
10	20	DUES & SUBSCRIPTION	PER RESIDENT DAY	182,408	7	3,048		22,808	381	10
11	21	OFFICE EXPENSE	PER RESIDENT DAY	182,408	7	203,894	145,953	22,808	25,495	11
12	24	TRAVEL & SEMINARS	PER RESIDENT DAY	182,408	7	5,891		22,808	737	12
13	25	TRANSPORTATION	PER RESIDENT DAY	182,408	7	15,730		22,808	1,967	13
14	26	INSURANCE	PER RESIDENT DAY	182,408	7	14,528		22,808	1,817	14
15	27	PAYROLL TAXES & GRP INS	PER RESIDENT DAY	182,408	7	147,729		22,808	18,472	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,088,386	\$ 806,417		\$ 136,092	25

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

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	16,870		79	2,086	2
3	33	REAL ESTATE	639	7	7,664		79	948	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				\$ 31,275	\$		\$ 3,867	25

Facility Name & ID Number

HILLSIDE REHABILITATION & CARE C

0047100

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	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1						\$	\$			\$	1									
2											2									
3	US BANK (HI PROP)	X	MORTGAGE (office)		6/29/05		31,861	6/29/12	0.0635	2,086	3									
4											4									
5											5									
Working Capital																				
6	COLE TAYLOR	X	WORKING CAPITAL	INT	REVOL		359,037	REVOL	PRIME +	27,052	6									
7											7									
8											8									
9	TOTAL Facility Related					\$	\$ 390,898			\$ 29,138	9									
B. Non-Facility Related*																				
10	IRS, IDR, ETC	X	LATE FEES								10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related					\$	\$			\$	14									
15	TOTALS (line 9+line14)					\$	\$ 390,898			\$ 29,138	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 2007 report.		\$	67,836	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.)		\$	75,653	2
3. Under or (over) accrual (line 2 minus line 1).		\$	7,818	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	75,653	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.		\$	83,471	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2003		8	
	2004	51,834	9	
	2005	67,078	10	
	2006	67,835	11	
	2007	75,653	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

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 HILLSIDE REHABILITATION & CARE CENTER COUNTY KENDALL

FACILITY IDPH LICENSE NUMBER 0047100

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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>02-29-278-001</u>	<u>NURSING HOME</u>	\$ <u>70,212.10</u>	\$ <u>70,212.10</u>
2. <u>02-29-278-008</u>	<u>NURSING HOME</u>	\$ <u>2,541.38</u>	\$ <u>2,541.38</u>
3. <u>02-29-278-015</u>	<u>NURSING HOME</u>	\$ <u>2,900.00</u>	\$ <u>2,900.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>75,653.48</u>	\$ <u>75,653.48</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.

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: 1,827 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>OFFICE BUILDING</u>		<u>2005</u>	<u>\$ 7,192</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 7,192	3

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

0047100

Report Period Beginning:

01/01/2008 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				\$	\$		\$	\$	\$	4	
5										5	
6										6	
7										7	
8										8	
Improvement Type**											
9	HEAT & SMOKE DETECTORS		2005	2,700	98	27.5	98			306	9
10	OUTDOOR LIGHTING		2005	2,450	163	15	163			510	10
11	SIDEWALKS		2005	3,250	217	15	217			678	11
12	BASEBOARD HEATER		2006	600	22	27.5	22			45	12
13	FIRESPRINKLER VALVE & ALARM PULL BOXES		2006	7,820	284	27.5	284			580	13
14	CARPETING		2006	716	137	5	143	6		429	14
15	RECEPTACLES		2007	2,549	93	27.5	93			136	15
16	FIRE SPRINKLER		2008	3,154	72	27.5	72			72	16
17											17
18											18
19											19
20											20
21	GREASE TRAP (PAID BY LANDLORD)		2008	18,595							21
22	H & I PROPERTIES		2005	32,513	833	39	833			3145	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

*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 **HILLSIDE REHABILITATION & CARE CENTER**

0047100

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	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)		\$ 74,347	\$ 1,919		\$ 1,925	\$ 6	\$ 5,901	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	\$ 3,435	\$ 1,963	\$ (1,472)		\$ 5,388	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 19,634	\$ 3,435	\$ 1,963	\$ (1,472)		\$ 5,388	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)	\$ 101,173	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 5,354	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 3,888	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,466)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 11,289	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, L.L.C.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO

If NO, see instructions.

		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	4/05/05	\$ 352,882	9		3
4	Additions							4
5								5
6								6
7	TOTAL		79		\$ 352,882			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: \$ 14,798 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. /2009 \$ 346,020

13. /2010 \$ 346,020

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	\$		\$ 89,008	\$		\$ 89,008	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			12,510			12,510	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			92,593			92,593	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				105,808		105,808	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$ 194,111	\$ 105,808		\$ 299,919	14

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

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

0047100

Report Period Beginning: **01/01/2008**

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	\$ 189,560	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (200,000))	1,001,546		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	52,086		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Real Estate Escrow Deposit</u>	85,617		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,328,809	\$	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	22,523		15
16	Equipment, at Historical Cost	42,272		16
17	Accumulated Depreciation (book methods)	(39,239)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 25,556	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,354,365	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 694,899	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	359,037		29
30	Accrued Salaries Payable	62,045		30
31	Accrued Taxes Payable (excluding real estate taxes)	24,587		31
32	Accrued Real Estate Taxes(Sch.IX-B)	75,653		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)	\$ 1,216,221	\$	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)	\$ 1,216,221	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 138,144	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,354,365	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 212,862	1
2	Restatements (describe):		2
3		(9,995)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 202,867	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(64,723)	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)	\$ (64,723)	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)	\$ 138,144	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	\$ 3,689,764	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,689,764	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	102,471	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 102,471	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***	3,119	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,119	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)	\$ 3,795,354	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	573,683	31
32	Health Care	1,453,539	32
33	General Administration	1,005,013	33
	B. Capital Expense		
34	Ownership	484,551	34
	C. Ancillary Expense		
35	Special Cost Centers	299,919	35
36	Provider Participation Fee	43,372	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,860,077	40
41	Income before Income Taxes (line 30 minus line 40)**	(64,723)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (64,723)	43

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

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

TAX RETURN PREPARED ON CASH BASIS

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

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

Facility Name & ID Number HILLSIDE REHABILITATION & CARE CENTER

0047100

Report Period Beginning: 01/01/2008

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	2,031	2,167	\$ 76,487	\$ 35.30	1
2	Assistant Director of Nursing	1,120	1,172	29,667	25.31	2
3	Registered Nurses	11,553	12,829	307,164	23.94	3
4	Licensed Practical Nurses	5,917	6,809	164,367	24.14	4
5	CNAs & Orderlies	45,193	49,118	551,884	11.24	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,670	2,953	37,913	12.84	8
9	Activity Director	1,834	2,109	29,126	13.81	9
10	Activity Assistants	639	769	8,751	11.38	10
11	Social Service Workers	498	502	6,715	13.38	11
12	Dietician					12
13	Food Service Supervisor	1,743	2,104	36,095	17.16	13
14	Head Cook	2,806	3,221	66,218	20.56	14
15	Cook Helpers/Assistants	6,086	6,792	31,118	4.58	15
16	Dishwashers					16
17	Maintenance Workers	1,998	2,221	29,910	13.47	17
18	Housekeepers	6,641	7,716	83,994	10.89	18
19	Laundry	2,578	2,853	29,412	10.31	19
20	Administrator	1,932	2,321	95,633	41.20	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,689	2,129	43,733	20.54	23
24	Clerical	2,815	3,297	53,711	16.29	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	903	1,154	25,783	22.34	31
32	Other Health C: <u>MDS</u>	1,922	2,213	54,750	24.74	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	102,568	114,449	\$ 1,762,431 *	\$ 15.40	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	148	\$ 7,437	1-3	35
36	Medical Director	monthly	11,050	9-3	36
37	Medical Records Consultant		1,245	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant		1,860	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		0	11-3	44
45	Social Service Consultant		1,023	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	148	\$ 22,615		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	\$ 64,553	Workers' Compensation Insurance	\$ 55,824	IDPH License Fee	\$		
JUDY KOZCO	ADMINISTRATOR	0	31,080	Unemployment Compensation Insurance	13,209	Advertising: Employee Recruitment	6,174		
			0	FICA Taxes	133,647	Health Care Worker Background Check	951		
				Employee Health Insurance	19,262	(Indicate # of checks performed <u>57</u>)			
				Employee Meals	0	Patient Background Checks	98		
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	348		
				EMPLOYEE BENEFITS - OTHER	5,864	MARKETING/ADV/PROMO	13,136		
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	8,446		
				PENSION/PROFIT SHARING PLANS	5,413	MGMT CO ALLOC	381		
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(348)		
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)		
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(7,728)		
						Yellow page advertising	(5,408)		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 95,633	TOTAL (agree to Schedule V, line 22, col.8)		\$ 233,219	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 17,520
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			\$ 149,911			\$	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)			\$ 149,911				Seminar Expense	3,484	
							MGMT CO ALLOC	737	
C. Professional Services				TOTAL			Entertainment Expense		
Vendor/Payee	Type		Amount	\$			()		
							(agree to Sch. V, line 24, col. 8)		
							TOTAL	\$ 4,221	
SEE ATTACHED			62,186						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 62,186						

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number **HILLSIDE REHABILITATION & CARE CENTER**# **0047100**Report Period Beginning: **01/01/2008**Ending: **12/31/2008****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? YES
If YES, give association name and amount. IL HEALTHCARE ASSC.\$ 3997.40
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (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. \$ 50,885 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. \$ 43,372
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