



Facility Name & ID Number HILLCREST NURSING & REHABILITATION CENTER

# 0050690 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			2,398	2,398	8
9	SNF/PED					9
10	ICF	53,285	212		53,497	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	53,285	212	2,398	55,895	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.15%

D. How many bed-hold days during this year were paid by the Department? 1,600 (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 11/01/09

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 11/01/09 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 2,398

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/09

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

Facility Name & ID Number HILLCREST NURSING & REHABILITATION # 0050690 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	186,104	22,443	9,802	218,349		218,349	218,349			1
2	Food Purchase		226,852		226,852	(13,907)	212,945	(181)	212,764		2
3	Housekeeping	196,339	33,812		230,151		230,151		230,151		3
4	Laundry	33,763	16,177	619	50,559		50,559		50,559		4
5	Heat and Other Utilities			154,662	154,662		154,662		154,662		5
6	Maintenance	34,499	53,397	74,769	162,665		162,665	17,078	179,743		6
7	Other (specify):* SECURITY	79,206		25,884	105,090		105,090	116	105,206		7
8	<b>TOTAL General Services</b>	529,911	352,681	265,736	1,148,328	(13,907)	1,134,421	17,013	1,151,434		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			16,600	16,600		16,600		16,600		9
10	Nursing and Medical Records	1,640,286	80,906	19,012	1,740,204		1,740,204	30,468	1,770,672		10
10a	Therapy	60,510	5,791	26,735	93,036		93,036	7,664	100,700		10a
11	Activities	77,560	52,209	18,163	147,932		147,932		147,932		11
12	Social Services	363,653			363,653		363,653		363,653		12
13	CNA Training										13
14	Program Transportation			504	504		504		504		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,142,009	138,906	81,014	2,361,929		2,361,929	38,132	2,400,061		16
	<b>C. General Administration</b>										
17	Administrative	157,404		225,000	382,404		382,404	(92,987)	289,417		17
18	Directors Fees										18
19	Professional Services			299,500	299,500		299,500	(243,687)	55,813		19
20	Dues, Fees, Subscriptions & Promotions			76,094	76,094		76,094	(53,815)	22,279		20
21	Clerical & General Office Expenses	48,698	25,102	239,857	313,657		313,657	(89,303)	224,354		21
22	Employee Benefits & Payroll Taxes			384,860	384,860	13,907	398,767		398,767		22
23	Inservice Training & Education			7,316	7,316		7,316	1,297	8,613		23
24	Travel and Seminar			20	20		20	260	280		24
25	Other Admin. Staff Transportation			1,186	1,186		1,186	13,340	14,526		25
26	Insurance-Prop.Liab.Malpractice			90,971	90,971		90,971	1,952	92,923		26
27	Other (specify):*			24,000	24,000		24,000	34,368	58,368		27
28	<b>TOTAL General Administration</b>	206,102	25,102	1,348,804	1,580,008	13,907	1,593,915	(428,575)	1,165,340		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,878,022	516,689	1,695,554	5,090,265		5,090,265	(373,430)	4,716,835		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
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	9,802
	REPAIRS & MAINTENANCE	0
		0
		9,802
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	619
		0
		619
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	19,364
	ELECTRICITY	90,126
	WATER	45,172
	CABLE TV - LOBBY	0
		0
		154,662
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	12,400
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	30,978
	ELEVATOR MAINTENANCE & REPAIR	9,765
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,675
	FIRE SERVICE	17,951
		0
		0
		0
		0
		74,769
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	25,884
	SECURITY SERVICE	0
		0
		0
		25,884
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	16,600
		16,600

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	2,796
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	2,016
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B 47-2	13,500
	RN CONSULTANT XVIII B 38-2	0
	DENTAL SERVICES	700
		0
		19,012
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	3,993
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	512
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
	THERAPY CONTRACT SERVICES	22,230
		26,735
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	18,163
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		18,163
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
		0
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0



V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	504
		0
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	225,000
	<b>DIRECTORS FEES</b>	
18	DIRECTORS FEES	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	39,597
	ADMINISTRATIVE CONSULTANTS XIX C	230,000
	PROFESSIONAL FEES XIX C	29,903
		0
		299,500
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	55,940
	EMPLOYEE WANT ADS XIX F	17,990
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	479
	LICENSES & PERMITS XIX F	1,525
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	125
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	35
	PATIENT BACKGROUND CHECKS XIX F	0
		76,094
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	89
	EQUIPMENT REPAIR & MAINTENANCE	14,446
	OUTSIDE CLERICAL SERVICES	114,660
	PENALTIES / OVERDRAFT CHARGES VI 18	22,011
	HOME OFFICE EXPENSE	61,525
	THEFT & DAMAGE LOSS	0
	TELEPHONE	26,204
	MESSENGER SERVICE	922
		0
		239,857

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	217,595
	UNEMPLOYMENT COMPENSATION XIX D	27,102
	WORKERS COMPENSATION INSURANC XIX D	66,714
	HOSPITALIZATION INSURANCE XIX D	33,996
	EMPLOYEE BENEFITS - OTHER XIX D	33,783
	EMPLOYEE PHYSICAL EXAMS XIX D	490
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	5,180
	CHICAGO HEAD TAX XIX D	0
		0
		384,860
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	7,316
		7,316
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	20
		20
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	1,186
		1,186
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	90,801
	GENERAL INSURANCE EXPENSE	170
		90,971
27	<b>OTHER</b>	
	BAD DEBTS VI 24	24,000
		24,000

GRAND TOTAL COLUMN 3 OTHER **1,695,554**

**HILLCREST NURSING & REHABILITATION CENTER  
SCHEDULES  
12/31/2009**

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

TOTAL FOOD PURCHASE	226,852
LESS SALES TAX	(181)
NET FOOD	<u>226,671</u>
TOTAL PATIENT CENSUS	55,895
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	<u>167,685</u>
ADD # EMPLOYEE MEALS/DAY	<u>30</u>
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	<u>10,950</u>
PATIENT MEALS	167,685
ADD EMPLOYEE MEALS	<u>10,950</u>
TOTAL MEALS/YEAR	<u>178,635</u>
NET FOOD	226,671
DIVIDE TOTAL MEALS/YEAR	<u>178,635</u>
COST PER MEAL	1.27
TIME EMPLOYEE MEALS	<u>10,950</u>
EMPLOYEE MEAL RECLASSIFICATION	<u><b>13,907</b></u>
	=====

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

CAREPLUS MGT	DATA PROCESSING	26,060
ACHIEVE HEALTHCARE	DATA PROCESSING	1,602
AMERICAN DATA	DATA PROCESSING	4,364
BATCH PROCESSING	DATA PROCESSING	245
e-HEALTH DATA SOLUTIONS	DATA PROCESSING	3,425
ADAPTASOFT	DATA PROCESSING	424
EMDEON	DATA PROCESSING	350
NATIONAL DATACARE	DATA PROCESSING	3,016
NEBO SYSTEMS	DATA PROCESSING	56
IVANS	DATA PROCESSING	56
CAREPLUS MGT	ADMIN CONSULTANT	190,000
EXTENDED CARE CONSULTING	ADMIN CONSULTANT	40,000
KRUPNICK, BOKOR, KAGDA, LTD	ACCOUNTING	11,950
GREEN DUBIN	ACCOUNTING	6,500
MEYER MAGENCE	LEGAL	5,287
ECONOCARE	PURCHASING SERVICE	2,268
PERSONNEL PLANNER	UC CONSULTANT	3,411
HONKAMP KRUEGER	WOTC CONSULTANT	486
		-----
<b>TOTAL PROFESSIONAL FEES</b>		<b>299,500</b>
		=====

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

<u>DATE</u>	<u>SPONSOR OF SEMINAR</u>
JAN	IMHCA
JAN	CRISIS PREVENTION
FEB	PESI HEALTHCARE
FEB	ICLTC
MAR	IHCA
APR	PATHWAY HEALTH SERVICES
MAY	PESI HEALTHCARE
MAY	CROSS COUNTRY EDUCATION
JUN	CREATIVE ACTION LLC
JUL	CAREER TRACK
JUL	PATHWAY HEALTH SERVICES
JUL	ICLTC
AUG	CROSS COUNTRY EDUCATION
SEP	ICLTC
DEC	COASTAL TRAINING TECH
DEC	FAMILY HEALTH MEDIA

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

UNIVERSAL HOSPITAL SVCS	NURSING EQUIPMENT	2,820
ACCENT NURSING	NURSING EQUIPMENT	1660

JOHNSON WATER CONDITION	PLANT EQUIPMENT	240
RENTAL MAX	PLANT EQUIPMENT	150
AIR CLEANING SPECIALISTS	SMOKEETERS	585
FAMILY PRIDE	WASHER/DRYER	8,580
GE CAPITAL	COPIER	8,392
PUBLIC STORAGE	STORAGE	2,098
PI TNEY BOWES	POSTAGE METER	224
		-----
<b>TOTAL EQUIPMENT RENTAL EXPENSE</b>		<b>24,749</b>
		=====

<b>SEMINAR PURPOSE</b>	<b>EMPLOYEE</b>	<b>LOC</b>	<b>COST</b>
ETHICAL DECISION MAKING IN CLINICAL SUPERVISION	C THERRIEN	IL	120.00
CRISIS PREVENTION		IL	118.07
TOXIC ANGER	K BELL	IL	184.00
NEW OBRA PAIN REQUIREMENTS	A WALKO, MJ BENSON, B SIMONSON	IL	385.00
NURSING HOME ADMINISTRATORS REVIEW COURSE	M HOUSER	IL	595.00
RESTORATIVE/REHAB CERTIFICATION PROGRAM FOR LICENSED NURSES	Y FULTZ	IL	789.00
CHALLENGING GERIATRIC BEHAVIORS	C THERRIEN, A WALKO, M HOUSER	IL	522.00
PROTECT YOUR FACILITY FROM INCREASED SURVEYOR SCRUTINY	C THERRIEN, B SIMON, A WALKO	IL	507.00
MEMORY MAGIC PROGRAM SET #1 & 2	KRISTINE & DENISE	IL	618.00
THE ULTIMATE SUPERVISOR	KEISHA V COOPER	IL	129.00
MDS SCHEDULING FOR OBRA AND PPS	PATSY & MELISSA	IL	278
HEAR IT DIRECTLY FROM THE SURVEYORS: WHAT'S NEEDED; WHAT'S MISSING	A WALKO-SPARKS, K ORLANDO	IL	190.00
DEVELOPING AND IMPLEMENTING RESTORATIVE PROGRAMS	K ORLANDO, P DERBAS, B SIMONSON, M HOUSER		756.00
NEW SURVIVAL TOOLS FOR THE MDS MEDICAID AUDIT	ANDREA PERRY NANCY COUGHLIN	IL	570
10 ASSORTED DVD'S FOR INSERVICE TRAINING		IL	1509.36
PRESSURE ULCER PREVENTION DVD FOR INSERVICE TRAINING		IL	46.13
			-----
	TOTAL		<b>7,316.56</b>
			=====



## 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	
	<b>D. Ownership</b>											
30	Depreciation			69,268	69,268	69,268	237,712	306,980				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,149	2,149	2,149	492,263	494,412				32
33	Real Estate Taxes			73,677	73,677	73,677	6,342	80,019				33
34	Rent-Facility & Grounds			608,479	608,479	608,479	(505,191)	103,288				34
35	Rent-Equipment & Vehicles			37,465	37,465	37,465	9,072	46,537				35
36	Other (specify):* OFFICE RENT			24,000	24,000	24,000	(24,000)					36
37	<b>TOTAL Ownership</b>			815,038	815,038	815,038	216,198	1,031,236				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		103,385	148,659	252,044	252,044		252,044				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			91,980	91,980	91,980		91,980				42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		103,385	240,639	344,024	344,024		344,024				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,878,022	620,074	2,751,231	6,249,327	6,249,327	(157,232)	6,092,095				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	(2,425)	30		9
10	Interest and Other Investment Income	(63,066)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(181)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(125)	20		17
18	Fines and Penalties	(22,011)	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	(24,000)	27		24
25	Fund Raising, Advertising and Promotional	(55,940)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (167,748)		\$	30

**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)	10,516		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 10,516		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (157,232)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

STATE OF ILLINOIS  
HILLCREST NURSING & REHABILITATION CENTER

Report Period Beginning:           01/01/2009            
Ending:                   12/31/2009          

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	<b>Total</b>		0	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number HILLCREST NURSING & REHABILITATION CENTER# 0050690

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(181)	0	0	0	0	0	0	0	0	0	0	(181)	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	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	17,073	5	0	0	0	0	0	0	0	0	17,078	6
7	Other (specify):*	0	116	0	0	0	0	0	0	0	0	0	116	7
8	<b>TOTAL General Services</b>	<b>(181)</b>	<b>17,189</b>	<b>5</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>17,013</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	30,468	0	0	0	0	0	0	0	0	0	30,468	10
10a	Therapy	0	7,664	0	0	0	0	0	0	0	0	0	7,664	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>38,132</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>38,132</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(92,987)	0	0	0	0	0	0	0	0	0	(92,987)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(205,937)	(40,000)	2,250	0	0	0	0	0	0	0	(243,687)	19
20	Fees, Subscriptions & Promotions	(56,065)	2,221	29	0	0	0	0	0	0	0	0	(53,815)	20
21	Clerical & General Office Expenses	(22,011)	(110,000)	42,708	0	0	0	0	0	0	0	0	(89,303)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	1,297	0	0	0	0	0	0	0	0	1,297	23
24	Travel and Seminar	0	0	260	0	0	0	0	0	0	0	0	260	24
25	Other Admin. Staff Transportation	0	0	13,340	0	0	0	0	0	0	0	0	13,340	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,952	0	0	0	0	0	0	0	0	1,952	26
27	Other (specify):*	(24,000)	0	58,368	0	0	0	0	0	0	0	0	34,368	27
28	<b>TOTAL General Administration</b>	<b>(102,076)</b>	<b>(406,703)</b>	<b>77,954</b>	<b>2,250</b>	<b>0</b>	<b>(428,575)</b>	<b>28</b>						
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(102,257)</b>	<b>(351,382)</b>	<b>77,959</b>	<b>2,250</b>	<b>0</b>	<b>(373,430)</b>	<b>29</b>						

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number HILLCREST NURSING & REHABILITATION CENTER# 0050690

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	(2,425)	0	14,246	225,891	0	0	0	0	0	0	0	237,712	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(63,066)	0	108,283	447,046	0	0	0	0	0	0	0	492,263	32
33	Real Estate Taxes	0	0	6,342	0	0	0	0	0	0	0	0	6,342	33
34	Rent-Facility & Grounds	0	0	0	(505,191)	0	0	0	0	0	0	0	(505,191)	34
35	Rent-Equipment & Vehicles	0	0	9,072	0	0	0	0	0	0	0	0	9,072	35
36	Other (specify):*	0	(24,000)	0	0	0	0	0	0	0	0	0	(24,000)	36
37	<b>TOTAL Ownership</b>	<b>(65,491)</b>	<b>(24,000)</b>	<b>137,943</b>	<b>167,746</b>	<b>0</b>	<b>216,198</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(167,748)</b>	<b>(375,382)</b>	<b>215,902</b>	<b>169,996</b>	<b>0</b>	<b>(157,232)</b>	<b>45</b>						

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				CAREPLUS MGMT	EVANSTON	MGMT/CLERICAL
				CAREPLUS REHABILITATIVE SERVICES		
SEE ATTACHED SCHEDULES					EVANSTON	THERAPY
				EXTENDED CARE CONSULTING		
					EVANSTON	MGMT/CLERICAL
				HILLCREST REALT	EVANSTON	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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 MANAGEMENT FEES	\$ 225,000	CAREPLUS MGMT INC		\$	\$ (225,000)	1
2	V	19 ADMIN. CONSULTANT FEES	190,000	" "			(190,000)	2
3	V	19 DATA PROCESSING FEES	26,060	" "			(26,060)	3
4	V	21 CLERICAL FEES	110,000	" "			(110,000)	4
5	V	36 OFFICE RENT	24,000	" "			(24,000)	5
6	V			" "				6
7	V	6 MAINTENANCE		" "		17,073	17,073	7
8	V	7 SECURITY		" "		116	116	8
9	V	10 NURSING		" "		30,468	30,468	9
10	V	10a THERAPY		" "		7,664	7,664	10
11	V	17 ADMIN		" "		132,013	132,013	11
12	V	19 PROFESSIONAL FEES		" "		10,123	10,123	12
13	V	20 DUES/LICENSES/WANT ADS		" "		2,221	2,221	13
14	Total		\$ 575,060			\$ 199,678	\$ * (375,382)	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		\$ 107,679	\$ 107,679
16	V	23 SEMINARS		" "		1,032	1,032
17	V	24 IN-STATE TRAVEL/LODGING		" "		251	251
18	V	25 TRANSPORTATION		" "		11,065	11,065
19	V	26 INSURANCE		" "		1,952	1,952
20	V	27 EMPLOYEE BENEFITS		" "		55,507	55,507
21	V	30 SL DEPRECIATION		" "		9,279	9,279
22	V	32 INTEREST		" "		108,283	108,283
23	V	33 REAL ESTATE TAX		" "		6,342	6,342
24	V	35 EQUIPMENT RENT		" "		9,072	9,072
25	V						
26	V	19 ADMINISTRATIVE CONSULTANT	40,000	EXTENDED CARE CONSULTING/CLINICAL			(40,000)
27	V	21 CLERICAL FEES	4,660	" "			(4,660)
28	V	21 HOME OFFICE EXPENSE	61,525	" "			(61,525)
29	V	6 MAINTENANCE & REPAIR		" "		5	5
30	V	20 DUES/LICENSES		" "		29	29
31	V	21 OFFICE EXPENSE		" "		1,214	1,214
32	V	23 SEMINARS		" "		265	265
33	V	24 TRAVEL		" "		9	9
34	V	25 TRANSPORTATION		" "		2,275	2,275
35	V	27 EMPLOYEE BENEFITS		" "		2,861	2,861
36	V						
37	V	30 SL DEPRECIATION		CAREPLUS REHABILITATIVE SERVICES		4,967	4,967
38	V						
39	Total		\$ 106,185			\$ 322,087	\$ * 215,902

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34 RENT	\$ 505,191	HILLCREST REALTY LLC		\$	(505,191)	15
16	V	30 SL DEPRECIATION		" "		225,891	225,891	16
17	V	32 INTEREST		" "		437,473	437,473	17
18	V	32 AMORT LOAN COST		" "		9,573	9,573	18
19	V	19 ACCOUNTING FEE		" "		2,250	2,250	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		\$ 505,191			\$ 675,187	\$ * 169,996	39

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

Facility Name & ID Number HILLCREST NURSING & REHABILITATION # 0050690 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

## VII. RELATED PARTIES (continued)

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

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

1	2	3	4	5	6		7		8	9	
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**				
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference		
1	<b>CAREPLUS MGMT ALLOCATIONS:</b>										
2	SHERWIN RAY	PRESIDENT	ADMIN/FINANCE	0.00	SEE ATTACHED	6.4	15.70	SALARY	30,616	17-7	2
3	JAKOB BAKST	DIR OPERAT'NS	ADMIN/CONS.	0.00	SCHEDULES	6.4	15.70	" "	30,616	17-7	3
4	ROSLYN INDICH	EXECUTIVE ASST	A/P MGMT	0.00	" "	6.4	15.70	" "	9,347	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 70,579		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 NURSING & REHABILITATION CENTER # 0050690 Report Period Beginning: 01/01/2009 Ending: 2/31/2009

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 2201 MAIN ST  
 City / State / Zip Code EVANSTON, IL 60202-1519  
 Phone Number ( 847)905-3000  
 Fax Number ( 847)491-9565

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	6	MAINTENANCE	CENSUS DAYS	8 FACILITIES	\$ 108,743	\$ 50,792	55,895	\$ 17,073	1
2	7	SECURITY	" "	8 FACILITIES	738		55,895	116	2
3	10	NURSING	" "	8 FACILITIES	194,059	194,059	55,895	30,468	3
4	10a	THERAPY	" "	8 FACILITIES	48,814	48,814	55,895	7,664	4
5	17	ADMIN SALARIES	" "	8 FACILITIES	840,831	840,831	55,895	132,013	5
6	19	PROFESSIONAL FEES	" "	8 FACILITIES	64,478		55,895	10,123	6
7	20	DUES/LICENSES/WANT ADS	" "	8 FACILITIES	14,148		55,895	2,221	7
8	21	OFFICE EXPENSES	" "	8 FACILITIES	685,841	547,685	55,895	107,679	8
9	23	SEMINARS	" "	8 FACILITIES	6,573		55,895	1,032	9
10	24	TRAVEL	" "	8 FACILITIES	1,601		55,895	251	10
11	25	TRANSPORTATION	" "	8 FACILITIES	70,475		55,895	11,065	11
12	26	INSURANCE	" "	8 FACILITIES	12,432		55,895	1,952	12
13	27	EMPLOYEE BENEFITS	" "	8 FACILITIES	353,538		55,895	55,507	13
14	30	SL DEPRECIATION	" "	8 FACILITIES	59,093		55,895	9,279	14
15	32	INTEREST-TAG MTG/LOC/EQ	" "	8 FACILITIES	689,687		55,895	108,283	15
16	33	REAL ESTATE TAX	" "	8 FACILITIES	40,394		55,895	6,342	16
17	35	EQUIP RENT/AUTO LEASE	" "	8 FACILITIES	57,785		55,895	9,072	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,249,230	\$ 1,682,181		\$ 510,140	25

Facility Name & ID Number HILLCREST NURSING & REHABILITATION CENTE # 0050690 Report Period Beginning: 01/01/2009 Ending: 2/31/2009

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 EXTENDED CARE CONSULTING  
 Street Address 2201 MAIN ST  
 City / State / Zip Code EVANSTON, IL 60202-1519  
 Phone Number ( 847)905-3000  
 Fax Number ( 847)491-9565

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	6	MAINTENANCE & REPAIR	CENSUS DAYS	8 FACILITIES	\$ 32	\$	9,340	\$ 5	1
2	20	DUES/LICENSES	" "	8 FACILITIES	184		9,340	29	2
3	21	OFFICE EXPENSES	" "	8 FACILITIES	7,605		9,340	1,214	3
4	23	SEMINARS	" "	8 FACILITIES	1,657		9,340	265	4
5	24	TRAVEL	" "	8 FACILITIES	57		9,340	9	5
6	25	TRANSPORTATION	" "	8 FACILITIES	14,249		9,340	2,275	6
7	27	EMPLOYEE BENEFITS	" "	8 FACILITIES	17,921		9,340	2,861	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				\$ 41,705	\$		\$ 6,658	25

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

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		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			
	<b>A. Directly Facility Related</b>																
	<b>Long-Term</b>																
1	RELATED PARTY: HILLCREST REALTY LLC						\$	\$			\$	1					
2	LAKE FOREST BK		X	MORTGAGE	\$50,519.11	02/07	6,400,000		02/22/12	7.1500	437,473	2					
3	LOAN COSTS		X	LOAN COSTS	W/O OVER LOAN	02/07	47,863	20,341	02/22/12		9,573	3					
4												4					
5												5					
	<b>Working Capital</b>																
6	INSURANCE FINANCING		X	INSURANCE FINANCE							2,149	6					
7	CAREPLUS MGMT ALLOCATION: TAG MTG INT/LOC										108,283	7					
8												8					
9	<b>TOTAL Facility Related</b>				\$50,519.11		\$ 6,447,863	\$ 20,341			\$ 557,478	9					
	<b>B. Non-Facility Related*</b>																
10												10					
11												11					
12												12					
13												13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14					
15	<b>TOTALS (line 9+line14)</b>						\$ 6,447,863	\$ 20,341			\$ 557,478	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

1. Real Estate Tax accrual used on 2008 report.	\$	<b>72,270</b>	<b>1</b>
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.)	\$	<b>72,380</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>110</b>	<b>3</b>
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>73,567</b>	<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		<b>5</b>
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. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<b>73,677</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004	<b>73,735</b>	<b>8</b>
	2005	<b>73,897</b>	<b>9</b>
	2006	<b>71,733</b>	<b>10</b>
	2007	<b>71,559</b>	<b>11</b>
	2008	<b>72,380</b>	<b>12</b>

<b>FOR BHF USE ONLY</b>			
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2008	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**THE CURRENT YEAR REAL ESTATE TAX ACCRUAL FOR HILLCREST HEALTHCARE CENTER INC IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL FOR 10 MONTHS = 60900 PLUS FOR HILLCREST NSG & REHAB CENTER LLC 2 MONTHS = 12667 THE PAYMENT ON LINE 2 APPLIES TO THE 2008 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.**



4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	\$ <u>72,380.06</u>	\$ <u>72,380.06</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 and 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 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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

Facility Name &amp; ID Number HILLCREST NURSING &amp; REHABILITATION CENTER

# 0050690

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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	192,291	27.5	192,291		412,752	5
6										6
7										7
8	HILLCREST HEALTHCARE CENTER INC:									8
	Improvement Type**									
9	LEASEHOLD IMPROVEMENTS		1991	6,230	198	31.5	198		3,598	9
10	LEASEHOLD IMPROVEMENTS		1992	48,072	1,525	31.5	1,526	1	26,705	10
11	LEASEHOLD IMPROVEMENTS		1993	33,291	981	31.5	1,057	76	17,440	11
12	LEASEHOLD IMPROVEMENTS		1994	10,172	261	39	261		4,013	12
13	ROOF REPAIR		1995	5,221	134	39	134		1,915	13
14	CONDENSING UNITS		1996	3,924	101	39	101		1,376	14
15	CEILING TILES		1996	1,334	34	39	34		458	15
16	ROOF REPAIR		1996	8,079	207	39	207		2,769	16
17	DOORS		1997	1,078	28	39	28		351	17
18	WINDOWS & ROOF VENTILATOR		1997	3,572	92	39	92		1,108	18
19	WINDOWS		1998	12,100	309	39	310	1	3,597	19
20	ROOF REPAIRS/DOORS/ELEC. REPAIRS/LOT LIGHTS		1998	23,693	607	39	607		7,017	20
21	WALLCOVER/RAILS/NURSE STNS/WINDOW TREATMENTS		1998	155,436	3,985	39	3,985		45,732	21
22	WINDOWS/DECORATING/CEILING TILE/ROOF REPAIR		1999	70,751	1,814	39	1,814		19,092	22
23	WINDOWS/FLOORING/DOOR		2000	12,169	442	27.5	442		4,260	23
24	CARPETING		2000	2,088		10	209	209	1,985	24
25	DOORS/ELEVATOR REPAIRS/SECURITY SYSTEM UPGRADE		2001	42,268	1,536	27.5	1,537	1	13,401	25
26	FENCE		2001	10,361	691	15	691		5,873	26
27	ROOF REPAIRS/CEILING TILE/FIRE DAMPERS/LIGHTING		2001	43,148	1,568	27.5	1,569	1	12,855	27
28	ROOF REPAIRS/HEAT/AC REPAIRS		2002	12,346	450	27.5	449	(1)	3,326	28
29	FENCE		2002	4,573	305	15	305		2,287	29
30	DOOR REPLACEMENTS/DUCTWORK-FIRE CODE		2003	7,297	266	27.5	265	(1)	1,769	30
31	DURO-LAST ROOF SYSTEM		2003	66,500	3,355	27.5	3,355		21,016	31
32	WALL A/C UNIT INSTALLATIONS / ELEVATOR BUTTONS		2003	92,265	2,418	27.5	2,418		15,415	32
33	FENCE / PARKING LOT SEAL		2003	8,816	588	15	588		3,822	33
34	EXTERIOR DOORS		2004	2,807	102	27.5	102		574	34
35	BATHROOM REMODELING		2004	2,500	91	27.5	91		504	35
36	SPRINKLERS/PIPING		2004	1,881	68	27.5	68		371	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 &amp; ID Number HILLCREST NURSING &amp; REHABILITATION CENTER

# 0050690

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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		\$ 1,248	37
38	BATHROOMS/KITCHEN REMODELING	2005	51,970	1,890	27.5	1,890		8,579	38
39	FIRE ALARM SYSTEM	2005	61,833	2,248	27.5	2,248		10,444	39
40	DOORS	2006	7,026	256	27.5	255	(1)	967	40
41	WALL A/C UNITS / SMOKE ROOM EXHAUST / TILE	2006	29,088	1,057	27.5	1,058	1	3,691	41
42	WALL A/C /DOORS/LOCKERS/GUTTERS/ELECTRICAL	2007	45,233	1,645	27.5	1,645		4,309	42
43	CEDAR FENCE	2007	9,600	640	15	640		1,600	43
44	DEMOLITION/FRAMING/INSULATION/DRYWALL/WALL TILE/FLOOR TILE/BASEBOARDS/PLUMBING/ELECTRICAL/TOILETS/SINKS/FIXT								44
45	WALL PREP/PAINTING/CARPETING	2008	136,414	4,960	27.5	4,960		9,301	45
46	ELEVATOR/DOORS/AC/DUCTWORK/SPRINKLER SYST	2008	238,390	8,667	27.5	8,667		11,771	46
47	BLACKTOP/SIDEWALK/PATIO/CONCRETE BENCHES	2008	20,200	1,347	15	1,347		2,020	47
48	ROOF DECK/SOFFIT/SPRINKLER HEADS/TOILETS/DOOR	2009	19,110	291	27.5	291		291	48
49									49
50	HILLCREST NURSING & REHABILITATION CENTER, LLC:								50
51	KITCHEN PIPING/WIRING	2009	8,272	38	27.5	38		38	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		4,378	57
58	CEILINGS/DRYWALL	2004	6,913	178	39	178		1,034	58
59	FIRE DAMPERS/DUCTWORK	2004	10,058	258	39	258		1,396	59
60									60
61									61
62	RELATED PARTY ALLOCATION - CAREPLUS MGMT								62
63	BUILDING-TAG-18 PROPERTIES	2004	58,244	2,374	39	2,374		9,814	63
64	BUILDING IMPROVEMENTS-TAG-18 PROPERTIES	2004	22,882	1,431	39	1,431		6,218	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)		\$ 6,741,866	\$ 242,750		\$ 243,037	\$ 287	\$ 712,480	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	\$ 244,418	\$ 13,202	\$ 18,016	\$ 4,814	8-15 YRS	\$ 152,000	71
72	Current Year Purchases	15,899	9,540	758	(8,782)	8-15 YRS	758	72
73	Fully Depreciated Assets							73
74	**REL'D PARTY-SL DEPN:CAREPL MGT, 5,464 /CP REHAB, 3,775/REALTY, 33,600		42,839	42,839				74
75	TOTALS	\$ 260,317	\$ 65,581	\$ 61,613	\$ (3,968)		\$ 152,758	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	\$ 1,074	\$ 2,330	\$ 1,256	4 YRS	\$ 8,155	76
77										77
78										78
79										79
80	TOTALS			\$ 9,319	\$ 1,074	\$ 2,330	\$ 1,256		\$ 8,155	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)	\$ 7,347,502	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 309,405	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 306,980	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (2,425)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 873,393	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

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

13. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

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: \$ 24,749 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>12,716</u>	17
18	<u>MAINT/BANKING/</u>				18
19	<u>ADMIN/ETC</u>				19
20					20
21	TOTAL		\$ <u>686.33</u>	\$ <u>12,716</u>	21

\* 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.

Facility Name & ID Number HILLCREST NURSING & REHABILITATION CENTER # 0050690 Report Period Beginning: 01/01/2009 Ending: 12/31/2009  
**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><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></p>	<p>2. <b>CLASSROOM PORTION:</b></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. <b>CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	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**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	9,707	\$		\$	9,707	1
2	Licensed Speech and Language Development Therapist	39-3	hrs				99				99	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39-3	hrs				138,853				138,853	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					100,355			100,355	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						3,030			3,030	13
14	<b>TOTAL</b>			\$		\$	148,659	\$	103,385	\$	252,044	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 NURSING & REHABILITATION CENTER # 0050690 Report Period Beginning: 01/01/2009 Ending: 12/31/2009  
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2009 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 10,258	\$	1
2	Cash-Patient Deposits	2,464		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>24,000</u> )	1,076,648		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	33,383		6
7	Other Prepaid Expenses	23,335		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>R.E.TAX ESCROW</u>	12,932		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,159,020	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	8,272		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(38)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 8,234	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,167,254	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 314,682	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	30,419		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,624		31
32	Accrued Real Estate Taxes(Sch.IX-B)	12,667		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>DUE TO RELATED PARTIES</u>	134,896		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 503,288	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>DUE TO PRIOR OPERATOR</u>	489,646		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 489,646	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 992,934	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 174,320	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,167,254	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$	<b>6</b>
<b>A. Additions (deductions):</b>			
<b>7</b>	NET Income (Loss) (from page 19, line 43)	1,118,495	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>ADJ FOR HILLCREST H/C CENTER INC</b>	(929,757)	<b>15</b>
<b>16</b>	Other (describe) <b>SALARY EXPENSE ADJ</b>	(14,418)	<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 174,320	<b>17</b>
<b>B. Transfers (Itemize):</b>			
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 174,320	<b>24</b> *

\* This must agree with page 17, line 47.

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 7,337,578	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 7,337,578	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	63,066	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 63,066	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,400,644	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,148,328	31
32	Health Care	2,361,929	32
33	General Administration	1,580,008	33
<b>B. Capital Expense</b>			
34	Ownership	815,038	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	252,044	35
36	Provider Participation Fee	91,980	36
<b>D. Other Expenses (specify):</b>			
37	<b>OUT-OF-PERIOD EXPENSES</b>	32,822	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,282,149	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,118,495	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,118,495	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 NURSING & REHABILITATION CENTER

# 0050690

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

**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	1,869	2,722	\$ 93,866	\$ 34.48	1
2	Assistant Director of Nursing	2,196	2,947	88,580	30.06	2
3	Registered Nurses	8,990	9,816	260,529	26.54	3
4	Licensed Practical Nurses	23,923	25,262	591,382	23.41	4
5	CNAs & Orderlies	38,246	42,531	409,996	9.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,735	5,613	60,510	10.78	8
9	Activity Director	1,916	2,138	35,556	16.63	9
10	Activity Assistants	4,497	5,167	42,004	8.13	10
11	Social Service Workers	20,513	21,925	363,653	16.59	11
12	Dietician					12
13	Food Service Supervisor	1,954	2,186	42,104	19.26	13
14	Head Cook	7,832	8,353	69,079	8.27	14
15	Cook Helpers/Assistants	8,712	9,532	74,921	7.86	15
16	Dishwashers					16
17	Maintenance Workers	2,023	2,233	34,499	15.45	17
18	Housekeepers	21,475	23,629	196,339	8.31	18
19	Laundry	3,484	3,917	33,763	8.62	19
20	Administrator	2,514	2,646	102,701	38.81	20
21	Assistant Administrator	2,279	2,388	54,703	22.91	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,714	3,955	48,698	12.31	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,943	2,146	22,770	10.61	31
32	Other Health C: <u>MDS/CPC</u>	5,329	5,930	173,163	29.20	32
33	Other(specify) <u>SECURITY</u>	8,970	9,601	79,206	8.25	33
34	TOTAL (lines 1 - 33)	177,114	194,637	\$ 2,878,022 *	\$ 14.79	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	\$ 9,802	1-3	35
36	Medical Director	O	16,600	9-3	36
37	Medical Records Consultant	N	0	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	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47	<u>PSYCHIATRIC</u>		13,500	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 41,918		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-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
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9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number HILLCREST NURSING & REHABILITATION CENTER# 0050690Report Period Beginning: 01/01/2009 Ending: 12/31/2009**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. \$ 75 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 X NO \_\_\_\_\_ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
HILLCREST HEALTHCARE CENTER INC #0037572 11/1/09
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 91,980  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 13,907 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: \_\_\_\_\_
- (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.