



Facility Name & ID Number Hillcrest Nursing & Rehab Center

# 0050690 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF		24	1,759	1,783	8
9	SNF/PED					9
10	ICF	52,846			52,846	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	52,846	24	1,759	54,629	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.09%

D. How many bed-hold days during this year were paid by the Department? None (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 12/16/2009

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 12/16/2009 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 84 and days of care provided 1,759

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: 12/31/10 Fiscal Year: 12/31/10

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

Facility Name & ID Number Hillcrest Nursing & Rehab Center # 0050690 Report Period Beginning: 01/01/10 Ending: 12/31/10

**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	197,076	44,590	11,644	253,310		253,310	3,581	256,891		1
2	Food Purchase		242,764		242,764		242,764	394	243,158		2
3	Housekeeping	195,926	42,853		238,779		238,779	55	238,834		3
4	Laundry	30,899	16,116		47,015		47,015	(361)	46,654		4
5	Heat and Other Utilities			141,446	141,446		141,446	1,271	142,717		5
6	Maintenance	188,579	459	136,340	325,378		325,378	14,167	339,545		6
7	Other (specify):*							1,776	1,776		7
8	<b>TOTAL General Services</b>	<b>612,480</b>	<b>346,782</b>	<b>289,430</b>	<b>1,248,692</b>		<b>1,248,692</b>	<b>20,883</b>	<b>1,269,575</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			40,250	40,250		40,250		40,250		9
10	Nursing and Medical Records	1,760,215	52,553	24,869	1,837,637		1,837,637	24,575	1,862,212		10
10a	Therapy	111,258			111,258		111,258	3,907	115,165		10a
11	Activities	94,483	20,335		114,818		114,818		114,818		11
12	Social Services	410,063	24,540	16,203	450,806		450,806	2,795	453,601		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							6,136	6,136		15
16	<b>TOTAL Health Care and Programs</b>	<b>2,376,019</b>	<b>97,428</b>	<b>81,322</b>	<b>2,554,769</b>		<b>2,554,769</b>	<b>37,413</b>	<b>2,592,182</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	177,706			177,706		177,706	91,326	269,032		17
18	Directors Fees										18
19	Professional Services			450,311	450,311		450,311	(263,304)	187,007		19
20	Dues, Fees, Subscriptions & Promotions			19,480	19,480		19,480	(8,578)	10,902		20
21	Clerical & General Office Expenses	64,056	23,023	213,207	300,286		300,286	(30,081)	270,205		21
22	Employee Benefits & Payroll Taxes			479,862	479,862		479,862	(22,478)	457,384		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,193	6,193		6,193	1,482	7,675		24
25	Other Admin. Staff Transportation			29,740	29,740		29,740	722	30,462		25
26	Insurance-Prop.Liab.Malpractice			116,865	116,865		116,865	944	117,809		26
27	Other (specify):*							33,984	33,984		27
28	<b>TOTAL General Administration</b>	<b>241,762</b>	<b>23,023</b>	<b>1,315,658</b>	<b>1,580,443</b>		<b>1,580,443</b>	<b>(195,982)</b>	<b>1,384,461</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,230,261</b>	<b>467,233</b>	<b>1,686,410</b>	<b>5,383,904</b>		<b>5,383,904</b>	<b>(137,686)</b>	<b>5,246,218</b>		<b>29</b>

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Hillcrest Nursing & Rehab Center #0050690 Report Period Beginning: 01/01/10 Ending: 12/31/10

## 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			2,062	2,062		2,062	226,815	228,877			30
31	Amortization of Pre-Op. & Org.			535	535		535	(535)	(0)			31
32	Interest			24,155	24,155		24,155	468,062	492,217			32
33	Real Estate Taxes			78,641	78,641		78,641	1,051	79,692			33
34	Rent-Facility & Grounds			645,484	645,484		645,484	(641,328)	4,156			34
35	Rent-Equipment & Vehicles			24,836	24,836		24,836	2,043	26,879			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			775,713	775,713		775,713	56,108	831,821			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		191,671	142,945	334,616		334,616	17,783	352,399			39
40	Barber and Beauty Shops			249	249		249		249			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>		191,671	235,174	426,845		426,845	17,783	444,628			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,230,261	658,904	2,697,297	6,586,462		6,586,462	(63,795)	6,522,667			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

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	(9,273)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1)	02		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				17
18	Fines and Penalties	(3,671)	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	(144,000)	21		24
25	Fund Raising, Advertising and Promotional	(11,722)	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	(40,371)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (209,038)		\$	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)	145,243		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 145,243		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (63,795)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					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	

SEE ACCOUNTANTS' COMPILATION REPORT

Hillcrest Nursing & Rehab Center

ID# 0050690

Report Period Beginning: 01/01/10

Ending: 12/31/10

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Theft Loss	\$ (682)	21	1
2	Collection Expense	(377)	21	2
3	Non-Allowable Amortization	(535)	31	3
4	Non-Allowable Promotion	(1,250)	19	4
5	Non-Allowable Professional Fees	(1,250)	19	5
6	Non-Allowable Legal Fees	(24,249)	19	6
7	Additional Legal Fees	125	19	7
8	Building Co- Bank Service Fee	(308)	21	8
9	Building Co-Amortization	(9,573)	36	9
10	Additional R&M	3,634	06	10
11	Patient Clothing	(2,160)	10	11
12	Non-Allowable Expense	(3,747)	21	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>	(40,371)		49

Hillcrest Nursing & Rehab Center

ID# 0050690

Report Period Beginning: 01/01/10

Ending: 12/31/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98			49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hillcrest Nursing & Rehab Center# 0050690

Report Period Beginning:

01/01/10

Ending:

12/31/10

## 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			142		4,198		(759)					3,581	1
2	Food Purchase	(1)		395									394	2
3	Housekeeping			508		56				(509)			55	3
4	Laundry									(361)			(361)	4
5	Heat and Other Utilities			1,153		118							1,271	5
6	Maintenance	3,634		3,314	7,109	117				(7)			14,167	6
7	Other (specify):*				1,188	588							1,776	7
8	<b>TOTAL General Services</b>	<b>3,633</b>		<b>5,512</b>	<b>8,297</b>	<b>5,077</b>		<b>(759)</b>		<b>(877)</b>			<b>20,883</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(2,160)				27,016				(281)			24,575	10
10a	Therapy					3,907							3,907	10a
11	Activities													11
12	Social Services					2,795							2,795	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					4,726	1,410						6,136	15
16	<b>TOTAL Health Care and Programs</b>	<b>(2,160)</b>				<b>38,444</b>	<b>1,410</b>			<b>(281)</b>			<b>37,413</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			2,348	9,119	38,665	41,194						91,326	17
18	Directors Fees													18
19	Professional Services	(26,624)		(220,410)		(16,270)							(263,304)	19
20	Fees, Subscriptions & Promotions	(11,722)		2,977		167							(8,578)	20
21	Clerical & General Office Expenses	(152,785)	308	13,911	110,534	7,101						(9,149)	(30,081)	21
22	Employee Benefits & Payroll Taxes				(15,953)		(6,346)			(179)			(22,478)	22
23	Inservice Training & Education													23
24	Travel and Seminar			145		1,337							1,482	24
25	Other Admin. Staff Transportation			722									722	25
26	Insurance-Prop.Liab.Malpractice			792		152							944	26
27	Other (specify):*				22,854	6,194	4,936						33,984	27
28	<b>TOTAL General Administration</b>	<b>(191,131)</b>	<b>308</b>	<b>(199,515)</b>	<b>126,554</b>	<b>37,346</b>	<b>39,784</b>			<b>(179)</b>		<b>(9,149)</b>	<b>(195,982)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(189,657)</b>	<b>308</b>	<b>(194,003)</b>	<b>134,851</b>	<b>80,867</b>	<b>41,194</b>	<b>(759)</b>		<b>(1,337)</b>		<b>(9,149)</b>	<b>(137,686)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Hillcrest Nursing & Rehab Center# 0050690

Report Period Beginning:

01/01/10

Ending:

12/31/10

## 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	(9,273)	230,998	4,281		809							226,815	30
31	Amortization of Pre-Op. & Org.	(535)											(535)	31
32	Interest		444,461	8,170		15,431							468,062	32
33	Real Estate Taxes		(790)	1,658		183							1,051	33
34	Rent-Facility & Grounds		(642,468)	1,140									(641,328)	34
35	Rent-Equipment & Vehicles			2,043									2,043	35
36	Other (specify):*	(9,573)	9,573											36
37	<b>TOTAL Ownership</b>	<b>(19,381)</b>	<b>41,774</b>	<b>17,292</b>		<b>16,423</b>							<b>56,108</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								19,785	(1,357)		(645)	17,783	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>								<b>19,785</b>	<b>(1,357)</b>		<b>(645)</b>	<b>17,783</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(209,038)	42,082	(176,711)	134,851	97,290	41,194	(759)	19,785	(2,694)		(9,794)	(63,795)	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
See Attached		See Attached		See Attached		
				Hillcrest Realty, LLC		

**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	34 Rental Income	\$ 642,468	Hillcrest Realty, LLC	100.00%	\$	\$ (642,468)	1
2	V	33 Rental Income-Property Taxes	78,642	Hillcrest Realty, LLC	100.00%		(78,642)	2
3	V	21 Bank Service Fee		Hillcrest Realty, LLC	100.00%	308	308	3
4	V	21 Filing Fees		Hillcrest Realty, LLC	100.00%			4
5	V	30 Depreciation Expense		Hillcrest Realty, LLC	100.00%	230,998	230,998	5
6	V	36 Amortization Expense		Hillcrest Realty, LLC	100.00%	9,573	9,573	6
7	V	33 Real Estate Taxes		Hillcrest Realty, LLC	100.00%	77,852	77,852	7
8	V	32 Interest Expense		Hillcrest Realty, LLC	100.00%	444,461	444,461	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 721,110			\$ 763,192	\$ * 42,082	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	01 Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 142	\$	142	15
16	V	02 Food		Extended Care Consulting, LLC	100.00%	395		395	16
17	V	03 Housekeeping		Extended Care Consulting, LLC	100.00%	508		508	17
18	V	05 Utilities		Extended Care Consulting, LLC	100.00%	1,153		1,153	18
19	V	06 Maintenance		Extended Care Consulting, LLC	100.00%	3,314		3,314	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	2,348		2,348	20
21	V	19 Professional Fees	251,650	Extended Care Consulting, LLC	100.00%	9,790		(220,410)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	2,977		2,977	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	13,911		13,911	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	145		145	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	722		722	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	792		792	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	4,281		4,281	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	8,170		8,170	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,658		1,658	29
30	V	34 Rent - Building		Extended Care Consulting, LLC	100.00%	1,140		1,140	30
31	V	35 Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	2,043		2,043	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 251,650			\$ 53,489	\$ *	(176,711)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	06 Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	7,109	\$	7,109	15
16	V	06 Maintenance (Direct)	1,614	Extended Care Consulting, LLC	100.00%	1,614			16
17	V	07 Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,188		1,188	17
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%				18
19	V	12 Admission (Direct)	1,648	Extended Care Consulting, LLC	100.00%	1,648			19
20	V	15 Emp. Ben. - Nursing (Direct)		Extended Care Consulting, LLC	100.00%				20
21	V	17 Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	9,119		9,119	21
22	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	110,534		110,534	22
23	V	21 Office and Clerical (Direct)	22,471	Extended Care Consulting, LLC	100.00%	22,471			23
24	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	19,995		19,995	24
25	V	27 Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	2,859		2,859	25
26	V	22 Employee Benefits	15,953	Extended Care Consulting, LLC	100.00%			(15,953)	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		\$ 41,686			\$ 176,537	\$ *	134,851	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	03 Housekeeping	\$	Extended Care Clinical, LLC	100.00%	\$ 56	\$	56	15
16	V	05 Utilities		Extended Care Clinical, LLC	100.00%	118		118	16
17	V	06 Maintenance		Extended Care Clinical, LLC	100.00%	117		117	17
18	V	19 Professional Fees	22,831	Extended Care Clinical, LLC	100.00%	6,561		(16,270)	18
19	V	20 Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	167		167	19
20	V	21 Office & Clerical		Extended Care Clinical, LLC	100.00%	1,567		1,567	20
21	V	24 Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,337		1,337	21
22	V	26 Insurance		Extended Care Clinical, LLC	100.00%	152		152	22
23	V	30 Depreciation		Extended Care Clinical, LLC	100.00%	809		809	23
24	V	32 Interest		Extended Care Clinical, LLC	100.00%	15,431		15,431	24
25	V	33 Real Estate Taxes		Extended Care Clinical, LLC	100.00%	183		183	25
26	V	01 Dietary Salary		Extended Care Clinical, LLC	100.00%	4,198		4,198	26
27	V	07 Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	588		588	27
28	V	10 Nursing Salary		Extended Care Clinical, LLC	100.00%	27,016		27,016	28
29	V	10a Rehab Salary		Extended Care Clinical, LLC	100.00%	3,907		3,907	29
30	V	12 Social Service Salary		Extended Care Clinical, LLC	100.00%	2,795		2,795	30
31	V	15 Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	4,726		4,726	31
32	V	17 Administration Salary		Extended Care Clinical, LLC	100.00%	38,665		38,665	32
33	V	21 Office Salary		Extended Care Clinical, LLC	100.00%	5,534		5,534	33
34	V	27 Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	6,194		6,194	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 22,831			\$ 120,121	\$ *	97,290	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01 Dietary Salary	\$	Extended Care Clinical, LLC	100.00%	\$	\$	15
16	V	07 Emp. Ben. - General		Extended Care Clinical, LLC	100.00%			16
17	V	10 Nursing Salary	13,831	Extended Care Clinical, LLC	100.00%	13,831		17
18	V	12 Social Service Salary	1,266	Extended Care Clinical, LLC	100.00%	1,266		18
19	V	15 Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	1,410	1,410	19
20	V	17 Administration Salary		Extended Care Clinical, LLC	100.00%	41,194	41,194	20
21	V	27 Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	4,936	4,936	21
22	V	22 Employee Benefits	6,346	Extended Care Clinical, LLC	100.00%		(6,346)	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		\$ 21,443			\$ 62,637	\$ * 41,194	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary Supplies, Supplements	\$ 1,710	Care Centers Health Systems, Inc.	100.00%	\$ 950	\$ (759)
16	V	10 Nursing Supplies		Care Centers Health Systems, Inc.	100.00%		
17	V	39 Ancillary Expense		Care Centers Health Systems, Inc.	100.00%		
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,710			\$ 950	\$ * (759)

\* 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	39 Therapy	\$ 134,871	TriCare Rehab	100.00%	\$ 154,656	\$	19,785	15
16	V								16
17	V								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		\$ 134,871			\$ 154,656	\$ *	19,785	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Xcel Supply, LLC	100.00%	\$		15
16	V	3 Housekeeping	7,642	Xcel Supply, LLC	100.00%	7,133	(509)	16
17	V	4 Laundry	5,415	Xcel Supply, LLC	100.00%	5,054	(361)	17
18	V	6 Repairs & Maintenance	109	Xcel Supply, LLC	100.00%	102	(7)	18
19	V	10 Nursing	4,212	Xcel Supply, LLC	100.00%	3,932	(281)	19
20	V	11 Activities		Xcel Supply, LLC	100.00%			20
21	V	12 Social Service		Xcel Supply, LLC	100.00%			21
22	V	20 Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%			22
23	V	21 Office And Clerical		Xcel Supply, LLC	100.00%			23
24	V	22 Employee Benefits	2,684	Xcel Supply, LLC	100.00%	2,505	(179)	24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary	20,360	Xcel Supply, LLC	100.00%	19,003	(1,357)	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		\$ 40,422			\$ 37,728	\$ * (2,694)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 104,804	\$ 104,804	15
16	V							16
17	V							17
18	V							18
19	V	22 Employee Health Insurance	104,804	CCS Employee Benefits Group	100.00%		(104,804)	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		\$ 104,804			\$ 104,804	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	21 Matrix Leasing	\$ 17,024	Vent Lease LLC	100.00%	\$ 7,875	\$ (9,149)
16	V	39 Ventilator Equipment	1,200	Vent Lease LLC	100.00%	555	(645)
17	V	39 Other Ancillary		Vent Lease LLC	100.00%		
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 18,224			\$ 8,430	\$ * (9,794)

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

Facility Name & ID Number Hillcrest Nursing & Rehab Center # 0050690 Report Period Beginning: 01/01/10 Ending: 12/31/10

## 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	Eric Rothner	Shareholder	Administrative	90.00%	See Attached	1.18	2.54%	Mgmt. Fees	\$		1
2	Mark Steinberg	Relative	Administrative		See Attached	1.99	3.62%	Al. Salary/Fees	5,775	17-7	2
3	Adam Vales	Relative	Clerical		See Attached	0.55	1.38%	Alloc. Salary	963	22-7	3
4	G. Matt Silvers	Relative	Administrative		See Attached	0.07	0.31%	Alloc. Salary	240	17-7	4
5											5
6											6
7											7
8											8
9	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only amounts anticipated to be considered allowable by										9
10	IL Dept. of HFS.										10
11											11
12											12
13								TOTAL	\$ 6,978		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hillcrest Nursing & Rehab Center

# 0050690

Report Period Beginning:

01/01/10

Ending: 12/31/10

**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 \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hillcrest Nursing & Rehab Center

# 0050690

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization Extended Care Consulting, LLC  
 Street Address 2201 West Main Street  
 City / State / Zip Code Evanston, Illinois 60202  
 Phone Number ( 847) 905-3000  
 Fax Number ( 847) 905-3030

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.

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	01	Dietary	Patient Days	1,512,273	34	\$ 3,931	\$ 54,629	\$ 142	1
2	02	Food	Patient Days	1,512,273	34	10,940	54,629	395	2
3	03	Housekeeping	Patient Days	1,512,273	34	14,059	54,629	508	3
4	05	Utilities	Patient Days	1,512,273	34	31,923	54,629	1,153	4
5	06	Maintenance	Patient Days	1,512,273	34	91,744	54,629	3,314	5
6	17	Administrative	Patient Days	1,512,273	34	65,000	54,629	2,348	6
7	19	Professional Fees	Patient Days	1,512,273	34	271,007	54,629	9,790	7
8	20	Dues and Subscriptions	Patient Days	1,512,273	34	82,419	54,629	2,977	8
9	21	Office and Clerical	Patient Days	1,512,273	34	385,083	54,629	13,911	9
10	24	Seminar and Travel	Patient Days	1,512,273	34	4,022	54,629	145	10
11	25	Other Staff Admin. Trans.	Patient Days	1,512,273	34	19,982	54,629	722	11
12	26	Insurance	Patient Days	1,512,273	34	21,934	54,629	792	12
13	30	Depreciation	Patient Days	1,512,273	34	118,510	54,629	4,281	13
14	32	Interest	Patient Days	1,512,273	34	226,162	54,629	8,170	14
15	33	Real Estate Taxes	Patient Days	1,512,273	34	45,910	54,629	1,658	15
16	34	Rent - Building	Patient Days	1,512,273	34	31,555	54,629	1,140	16
17	35	Rent - Equipment & Auto	Patient Days	1,512,273	34	56,569	54,629	2,043	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,480,749	\$	\$ 53,489	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hillcrest Nursing & Rehab Center

# 0050690

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization Extended Care Consulting, LLC  
 Street Address 2201 West Main Street  
 City / State / Zip Code Evanston, Illinois 60202  
 Phone Number ( 847) 905-3000  
 Fax Number ( 847) 905-3030

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.

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	06	Maintenance (Pooled)	Patient Days	34	196,794	196,794	54,629	7,109	1
2	06	Maintenance (Direct)	Direct	34	32,478	32,478		1,614	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	34	32,885		54,629	1,188	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct	34	3,607				4
5	12	Admission (Direct)	Direct	34	52,036	52,036		1,648	5
6	15	Emp. Ben. - Nursing (Direct)	Direct	34	5,270				6
7	17	Administrative (Pooled)	Patient Days	34	252,448	252,448	54,629	9,119	7
8	21	Office and Clerical (Pooled)	Patient Days	34	3,059,876	3,059,876	54,629	110,534	8
9	21	Office and Clerical (Direct)	Direct	34	771,063	771,063		22,471	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	34	553,505		54,629	19,995	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct	34	94,865			2,859	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				\$ 5,054,827	\$ 4,364,695		\$ 176,537	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hillcrest Nursing & Rehab Center

# 0050690

Report Period Beginning:

01/01/10

Ending: 12/31/10

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 Clinical, LLC  
 Street Address 2201 West Main Street  
 City / State / Zip Code Evanston, Illinois 60202  
 Phone Number ( 847) 905-3000  
 Fax Number ( 847) 905-3030

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	03	Housekeeping	Patient Days	1,512,273	34	\$ 1,549	\$ 54,629	\$ 56	1
2	05	Utilities	Patient Days	1,512,273	34	3,268	54,629	118	2
3	06	Maintenance	Patient Days	1,512,273	34	3,240	54,629	117	3
4	19	Professional Fees	Patient Days	1,512,273	34	181,624	54,629	6,561	4
5	20	Dues and Subscriptions	Patient Days	1,512,273	34	4,624	54,629	167	5
6	21	Office & Clerical	Patient Days	1,512,273	34	43,370	54,629	1,567	6
7	24	Travel and Seminar	Patient Days	1,512,273	34	37,025	54,629	1,337	7
8	26	Insurance	Patient Days	1,512,273	34	4,213	54,629	152	8
9	30	Depreciation	Patient Days	1,512,273	34	22,389	54,629	809	9
10	32	Interest	Patient Days	1,512,273	34	427,165	54,629	15,431	10
11	33	Real Estate Taxes	Patient Days	1,512,273	34	5,058	54,629	183	11
12	01	Dietary Salary	Patient Days	1,512,273	34	116,221	54,629	4,198	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	1,512,273	34	16,288	54,629	588	13
14	10	Nursing Salary	Patient Days	1,512,273	34	747,870	54,629	27,016	14
15	10a	Rehab Salary	Patient Days	1,512,273	34	108,151	54,629	3,907	15
16	12	Social Service Salary	Patient Days	1,512,273	34	77,377	54,629	2,795	16
17	15	Emp. Ben. - Healthcare	Patient Days	1,512,273	34	130,816	54,629	4,726	17
18	17	Administration Salary	Patient Days	1,512,273	34	1,070,339	54,629	38,665	18
19	21	Office Salary	Patient Days	1,512,273	34	153,206	54,629	5,534	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	1,512,273	34	171,480	54,629	6,194	20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,325,274	\$ 2,273,164	\$ 120,121	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hillcrest Nursing & Rehab Center

# 0050690

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Extended Care Clinical, LLC

Street Address

2201 West Main Street

City / State / Zip Code

Evanston, Illinois 60202

Phone Number

( 847) 905-3000

Fax Number

( 847) 905-3030

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.

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	01	Dietary Salary	Direct Allocation		\$ 15,960	\$ 15,960		\$	1
2	07	Emp. Ben. - General	Direct Allocation		1,662				2
3	10	Nursing Salary	Direct Allocation		495,330	495,330		13,831	3
4	12	Social Service Salary	Direct Allocation		274,597	274,597		1,266	4
5	15	Emp. Ben. - Healthcare	Direct Allocation		94,697			1,410	5
6	17	Administration Salary	Direct Allocation		82,389	82,389		41,194	6
7	27	Emp. Ben. - Gen. Admin.	Direct Allocation		10,053			4,936	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				\$ 974,688	\$ 868,276		\$ 62,637	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hillcrest Nursing & Rehab Center

# 0050690

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Care Centers Health Systems, Inc.

Street Address

200 Howard

City / State / Zip Code

Des Plaines, Illinois 60018

Phone Number

( 224) 612-5662

Fax Number

( 224) 612-5862

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.

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	1	Dietary Supplies, Supplements	Direct Allocation		\$	\$		\$ 950	1
2	10	Nursing Supplies	Direct Allocation						2
3	39	Ancillary Expense	Direct Allocation						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				\$	\$		\$ 950	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hillcrest Nursing & Rehab Center

# 0050690

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

TriCare Rehab

Street Address

150 Fencil Lane

City / State / Zip Code

Hillside, IL 60162

Phone Number

( 773) 449-9400

Fax Number

( 773) 449-9700

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.

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	39	Therapy	Direct Allocation		\$	\$		\$ 154,656	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	TOTALS				\$	\$		\$ 154,656	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hillcrest Nursing & Rehab Center

# 0050690

Report Period Beginning:

01/01/10

Ending: 12/31/10

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 Xcel Supply, LLC  
 Street Address 2201 Main Street  
 City / State / Zip Code Evanston, IL 60202  
 Phone Number ( 847)328-7600  
 Fax Number ( 847)328-7615

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	1	Dietary	Direct Allocation		\$	\$		\$	1
2	3	Housekeeping	Direct Allocation					7,133	2
3	4	Laundry	Direct Allocation					5,054	3
4	6	Repairs & Maintenance	Direct Allocation					102	4
5	10	Nursing	Direct Allocation					3,932	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation						7
8	20	Dues, Fees And Subscriptions	Direct Allocation						8
9	21	Office And Clerical	Direct Allocation						9
10	22	Employee Benefits	Direct Allocation					2,505	10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation					19,003	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				\$	\$		\$	37,728

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hillcrest Nursing & Rehab Center

# 0050690

Report Period Beginning:

01/01/10

Ending: 12/31/10

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 CCS Employee Benefits Group, Inc.  
 Street Address 2201 Main Street  
 City / State / Zip Code Evanston, Illinois 60202  
 Phone Number ( 847)905-4000  
 Fax Number ( 847)905-4040

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation		\$	\$		\$ 104,804	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	TOTALS				\$	\$		\$ 104,804	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hillcrest Nursing & Rehab Center

# 0050690

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Vent Lease, LLC

Street Address

2201 W. Main Street

City / State / Zip Code

Evanston, Illinois 60202

Phone Number

( 847) 674-1180

Fax Number

( 847) 673-7741

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.

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	21	Matrix Leasing	Direct Allocation		\$	\$		7,875	1
2	39	Ventilator Equipment	Direct Allocation					555	2
3	39	Other Ancillary	Direct Allocation						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				\$	\$		8,430	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Hillcrest Nursing & Rehab Center

# 0050690

Report Period Beginning:

01/01/10

Ending:

12/31/10

**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										
										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	Lake Forest		X	Mortgage			\$	\$ 5,761,224		\$ 444,462	1								
2											2								
3											3								
4											4								
5	See Supplemental Schedule										5								
<b>Working Capital</b>																			
6	HFG		X	Line of Credit						(6,882)	6								
7	First Bank									26,250	7								
8	See Supplemental Schedule							36,825		28,388	8								
9	TOTAL Facility Related						\$	\$ 5,798,049		\$ 492,218	9								
<b>B. Non-Facility Related*</b>																			
10											10								
11											11								
12											12								
13	See Supplemental Schedule										13								
14	TOTAL Non-Facility Related						\$	\$		\$	14								
15	TOTALS (line 9+line14)						\$	\$ 5,798,049		\$ 492,218	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ None                      Line # N/A

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Hillcrest Nursing & Rehab Center

# 0050690

Report Period Beginning:

01/01/10

Ending:

12/31/10

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE**

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

1	2	3	4	5	6		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
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1						\$	\$			\$	1							
2											2							
3											3							
4											4							
5											5							
6											6							
7	<b>TOTAL Long-Term</b>										7							
<b>Working Capital</b>																		
8	Alloc from Ext Care Const, LLC	X				\$	\$			\$	8,170	8						
9	Alloc from Ext Care Clinical	X									15,431	9						
10	Homewood Loan	X									4,787	10						
11	Note Payable	X					36,825					11						
12												12						
13												13						
14	<b>TOTAL Working Capital</b>										14							
<b>B. Non-Facility Related*</b>																		
15						\$	\$			\$		15						
16												16						
17												17						
18												18						
19												19						
20	<b>TOTAL Non-Facility Related</b>										20							

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

Facility Name & ID Number **Hillcrest Nursing & Rehab Center**

# **0050690**

Report Period Beginning: **01/01/10**

Ending:

**12/31/10**

**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 2009 report.		\$	<b>75,997</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>76,889</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>892</b>	<b>3</b>
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>78,800</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>79,692</b>	<b>7</b>
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2005	<b>73,897</b>	<b>8</b>	
	2006	<b>71,733</b>	<b>9</b>	
	2007	<b>71,559</b>	<b>10</b>	
	2008	<b>72,380</b>	<b>11</b>	
	2009	<b>75,048</b>	<b>12</b>	
	<b>FOR BHF USE ONLY</b>			
	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2009	\$	<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>
<b>Allocation from Extended Care Consulting Building Alloc. \$1,658</b>				
<b>Allocation from Extended Care Clinical Building Alloc. \$183</b>				

**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.**

**SEE ACCOUNTANTS' COMPILATION REPORT**



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 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 Office of Health Finance at (217) 782-1630.

**2008 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Hillcrest Nursing & Rehab Center COUNTY Will

FACILITY IDPH LICENSE NUMBER 0050690

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(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.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
<b>TOTALS</b>			\$ _____	\$ _____

**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            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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original second installment tax bill.

Facility Name & ID Number Hillcrest Nursing & Rehab Center

# 0050690

Report Period Beginning:

01/01/10

Ending:

12/31/10

**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).

None

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>Facility</u>	<u>132,928</u>	<u>2007</u>	<u>\$ 336,000</u>	<u>1</u>
2	<u>Alloc. from Ext. Care Conslt/ Ext Care Clinical 2201 Main</u>			<u>13,258</u>	<u>2</u>
3	<b>TOTALS</b>	<b>132,928</b>		<b>\$ 349,258</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

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	Various		1991	6,230		20	198	198	3,796	9
10	Various		1992	48,072		20	1,526	1,526	28,231	10
11	Various		1993	33,291		20	1,057	1,057	18,497	11
12	Various		1994	10,172		20	261	261	4,274	12
13	Various		1995	5,221		20	134	134	2,049	13
14	Various		1996	13,337		20	342	342	4,945	14
15	Various		1997	4,650		20	120	120	1,579	15
16	Various		1998	191,229		20	4,902	4,902	61,248	16
17	Various		1999	70,751		20	1,814	1,814	20,906	17
18	Various		2000	14,257		20	545	545	6,790	18
19	Various		2001	95,777		20	3,797	3,797	35,926	19
20	Various		2002	16,919		20	754	754	6,367	20
21	Various		2003	174,878		20	6,626	6,626	48,648	21
22	Various		2004	7,188		20	261	261	1,710	22
23	Various		2005	120,877		20	4,395	4,395	24,666	23
24	Various		2006	36,114		20	1,313	1,313	5,971	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

SEE ACCOUNTANTS' COMPILATION REPORT

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		5,288,213	192,291		135,595	(56,696)	661,747	67
68		53,432	3,636		3,636		25,467	68
69			2,062			(2,062)		69
70		\$ 6,190,608	\$ 197,989		\$ 167,276	\$ (30,713)	\$ 962,817	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Hillcrest Nursing & Rehab Center

# 0050690

Report Period Beginning:

01/01/10

Ending:

12/31/10

**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	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 6,190,608	\$ 197,989		\$ 167,276	\$ (30,713)	\$ 962,817	1
2	Wall A/C, Doors, Lockers, Gutters, Electrical	2007	45,233		20	1,645	1,645	5,954	2
3	Cedar Fence	2007	9,600		20	640	640	2,240	3
4	Demolition,Framing,Insulation,Drywall,Tile,Baseboard,Plumbing,	2008	136,414		20	4,960	4,960	14,261	4
5	Elevator, Doors, A/C, Ductwork, Sprinkler System	2008	238,390		20	8,667	8,667	20,438	5
6	Blacktop, Sidewalk, Patio, Concrete Benches	2008	20,200		20	1,347	1,347	3,367	6
7	Roof Deck, Soffit, Sprinkler Heads, Toilets, Doors	2009	19,110		20	956	956	1,247	7
8	Kitchen Piping/Wiring	2009	8,272		20	38	38	76	8
9	Sidewalk Renovations	2010	4,750		20	238	238	238	9
10	Security System-Replace Vdr & 7 Cameras	2010	3,600		20	180	180	180	10
11	Replace Water Heater	2010	2,585		20	129	129	129	11
12	Replace Main Ltg & Htg Circuit Breakers	2010	14,400		20	720	720	720	12
13	Replace Kitchen Heating/Cooling Unit	2010	7,100		20	355	355	355	13
14	Electrical Work For 4 Rms On 2Nd Flr & Main Dining Rm	2010	4,150		20	208	208	208	14
15	Shingle,Drain & Downspout Replacement	2010	10,380		20	519	519	519	15
16	Duro Last Drains	2010	3,400		20	170	170	170	16
17	Painting	2010	15,831		20	792	792	792	17
18	5 Ptac Type Air Conditioning Units	2010	3,288		20	164	164	164	18
19	Remove & Replace Generator	2010	7,500		20	375	375	375	19
20	6 Ptac Type Air Conditioning Units	2010	3,476		20	174	174	174	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,748,287	\$ 197,989		\$ 189,552	\$ (8,438)	\$ 1,014,422	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	
1		\$ 6,748,287	\$ 197,989		\$ 189,552	\$ (8,438)	\$ 1,014,422	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		\$ 6,748,287	\$ 197,989		\$ 189,552	\$ (8,438)	\$ 1,014,422	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	
1		\$ 6,748,287	\$ 197,989		\$ 189,552	\$ (8,438)	\$ 1,014,422	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	TOTAL (lines 1 thru 33)	\$ 6,748,287	\$ 197,989		\$ 189,552	\$ (8,438)	\$ 1,014,422	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Hillcrest Nursing & Rehab Center

# 0050690

Report Period Beginning:

01/01/10

Ending:

12/31/10

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	
1		\$ 6,748,287	\$ 197,989		\$ 189,552	\$ (8,438)	\$ 1,014,422	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		\$ 6,748,287	\$ 197,989		\$ 189,552	\$ (8,438)	\$ 1,014,422	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Hillcrest Nursing & Rehab Center

# 0050690

Report Period Beginning:

01/01/10

Ending:

12/31/10

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Building Company Information</b>								1
2	<b>Buildings:</b>								2
3	<b>Facility</b>	1976	5,288,213	192,291	39	135,595	(56,696)	661,747	3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Hillcrest Nursing & Rehab Center

# 0050690

Report Period Beginning:

01/01/10

Ending:

12/31/10

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Building Company Information Continued</b>		\$	\$		\$	\$	\$	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	<b>TOTAL (12F &amp; 12G lines 1 thru 33)</b>		\$ 5,288,213	\$ 192,291		\$ 135,595	\$ (56,696)	\$ 661,747	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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		
1	<b>Related Party Information</b>		\$	\$		\$	\$		1
2	<b>Buildings:</b>								2
3	Allocated from Extended Care Consulting, 2201 Main LLC	2002	16,457	422	39	422		3,499	3
4	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2002	1,813	46	39	46		385	4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9	Allocated from Extended Care Consulting	2007	166	8	20	8		33	9
10	Allocated from Extended Care Consulting	2009	99	5	20	5		10	10
11	Allocated from Extended Care Consulting	2010	975	49	20	49		49	11
12									12
13	Allocated from Extended Care Consulting, 2201 Main LLC	2002	13,594	1,242	20	1,242		8,709	13
14	Allocated from Extended Care Consulting, 2201 Main LLC	2003	16,021	1,464	20	1,464		10,263	14
15	Allocated from Extended Care Consulting, 2201 Main LLC	2005	796	85	20	85		372	15
16	Allocated from Extended Care Consulting, 2201 Main LLC	2009	144	7	20	7		14	16
17									17
18	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2002	1,498	137	20	137		959	18
19	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2003	1,765	161	20	161		1,131	19
20	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2005	88	9	20	9		41	20
21	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2009	16	1	20	1		2	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Hillcrest Nursing & Rehab Center

# 0050690

Report Period Beginning:

01/01/10

Ending:

12/31/10

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	
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	TOTAL (12H & 12I lines 1 thru 33)		\$ 53,432	\$ 3,636		\$ 3,636	\$ 25,467	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Hillcrest Nursing & Rehab Center

# 0050690

Report Period Beginning:

01/01/10

Ending:

12/31/10

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	\$ 268,466	\$ 815	\$ 20,421	\$ 19,606	10	\$ 176,982	71
72	Current Year Purchases	339,543	38,760	17,155	(21,605)	10	278,294	72
73	Fully Depreciated Assets	102,391				10	102,391	73
74								74
75	TOTALS	\$ 710,400	\$ 39,575	\$ 37,576	\$ (2,000)		\$ 557,667	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		2002 DODGE RAM BR150	2006	\$ 9,319	\$	\$ 1,164	\$ 1,164	5	\$ 9,319	76
77		Allocated From EC Consulting	2010	11,616	181	181		5	11,253	77
78		Allocated From EC Clinical	2010	2,019	404	404		5	942	78
79										79
80	TOTALS			\$ 22,954	\$ 585	\$ 1,749	\$ 1,164		\$ 21,514	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)	\$ 7,830,899	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 238,149	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 228,876	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (9,273)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,593,603	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.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: N/A

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	Allocated from Extended Care Consulting, LLC			1,140			5
6	Off-site Storage Rental			3,016			6
7	TOTAL			\$ 4,156			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: \$ 22,196 Description: See Attached Schedule

(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	Facility	2002 Dodge Ram	\$	\$ 4,683	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 4,683	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2013 \$ \_\_\_\_\_

\* 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>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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 - 03	hrs	\$		\$ 52,295	\$		\$ 52,295	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			31,092			31,092	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			57,751			57,751	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				115,504		115,504	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See Supplemental</u>					1,807	76,167		77,974	13
14	<b>TOTAL</b>			\$		\$ 142,945	\$ 191,671		\$ 334,616	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Hillcrest Nursing & Rehab Center**# **0050690**Report Period Beginning: **01/01/10**

Ending:

**12/31/10****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/10**

(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	\$	\$ 287	1
2	Cash-Patient Deposits	26,645	26,645	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	495,364	495,364	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	57,640	57,640	6
7	Other Prepaid Expenses	22,525	22,525	7
8	Accounts Receivable (owners or related parties)	762,190	762,190	8
9	Other(specify): <u>See Attached Schedule</u>	1,577,437	2,040,464	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,941,801	\$ 3,405,115	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		336,000	13
14	Buildings, at Historical Cost		5,288,000	14
15	Leasehold Improvements, at Historical Cost	76,034	76,034	15
16	Equipment, at Historical Cost	19,348	355,348	16
17	Accumulated Depreciation (book methods)	(2,062)	(941,748)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		47,863	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(37,095)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	4,281	(36,434)	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 97,601	\$ 5,087,968	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,039,402	\$ 8,493,083	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 968,539	\$ 968,548	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	26,883	26,883	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	205,178	205,178	30
31	Accrued Taxes Payable (excluding real estate taxes)	32,337	111,137	31
32	Accrued Real Estate Taxes(Sch.IX-B)	78,800	78,800	32
33	Accrued Interest Payable		23,429	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached Schedule</u>	795,241	795,241	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,106,978	\$ 2,209,216	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,798,049	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>See Attached Schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 5,798,049	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,106,978	\$ 8,007,265	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 932,424	\$ 485,818	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,039,402	\$ 8,493,083	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>174,354</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>174,354</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	\$ <b>758,070</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>758,070</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>932,424</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Hillcrest Nursing &amp; Rehab Center

# 0050690

Report Period Beginning: 01/01/10

Ending: 12/31/10

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	\$ 7,268,824	1
2	Discounts and Allowances for all Levels	(323,907)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,944,917	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	330,756	6
7	Oxygen	1,352	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 332,108	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	66,146	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,361	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>	\$ 67,507	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<a href="#">See Supplemental Schedule</a>		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>	\$ 7,344,532	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,248,692	31
32	Health Care	2,554,769	32
33	General Administration	1,580,443	33
<b>B. Capital Expense</b>			
34	Ownership	775,713	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	334,865	35
36	Provider Participation Fee	91,980	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,586,462	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	758,070	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 758,070	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

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

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

Facility Name & ID Number Hillcrest Nursing & Rehab Center

# 0050690

Report Period Beginning:

01/01/10

Ending:

12/31/10

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	2,062	2,408	\$ 100,841	\$ 41.88	1
2	Assistant Director of Nursing	2,047	2,260	107,683	47.65	2
3	Registered Nurses	15,923	17,391	476,646	27.41	3
4	Licensed Practical Nurses	22,700	24,325	579,240	23.81	4
5	CNAs & Orderlies	41,646	47,547	464,743	9.77	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,399	7,674	111,258	14.50	8
9	Activity Director	1,802	1,986	31,937	16.08	9
10	Activity Assistants	6,496	7,289	62,546	8.58	10
11	Social Service Workers	21,623	23,533	410,063	17.43	11
12	Dietician					12
13	Food Service Supervisor	1,813	2,123	44,310	20.87	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,811	17,660	152,766	8.65	15
16	Dishwashers					16
17	Maintenance Workers	16,259	17,596	188,579	10.72	17
18	Housekeepers	19,778	22,253	195,926	8.80	18
19	Laundry	2,763	3,213	30,899	9.62	19
20	Administrator	1,986	2,508	114,267	45.56	20
21	Assistant Administrator	1,597	1,792	63,439	35.40	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,109	4,465	64,056	14.35	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,084	2,344	26,552	11.33	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	213	219	4,510	20.59	33
34	TOTAL (lines 1 - 33)	187,111	208,586	\$ 3,230,261 *	\$ 15.49	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	227	\$ 11,644	01-03	35
36	Medical Director	Monthly	40,250	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	9,838	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Psycho Social Cons.</u>	Monthly	9,000	12-03	46
47	<u>Dental Consultant</u>	Monthly	1,200	10-03	47
48	<u>See Attached</u>		21,035		48
49	TOTAL (lines 35 - 48)	227	\$ 92,967		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

SEE ACCOUNTANTS' COMPILATION REPORT

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Amy Sparks	Administrator	0.00	\$ 114,267	Workers' Compensation Insurance	\$ 61,297	IDPH License Fee	\$ 2,574	
Melissa Houser	Assist. Admin	0.00	63,439	Unemployment Compensation Insurance	43,231	Advertising: Employee Recruitment	423	
				FICA Taxes	233,601	Health Care Worker Background Check	3,464	
				Employee Health Insurance	69,607	(Indicate # of checks performed <u>210</u> )		
				Employee Meals		<u>Patient Background Checks</u>		
				Illinois Municipal Retirement Fund (IMRF)*		<u>Dues &amp; Subscriptions</u>	76	
				<u>Employee Physicals</u>	3,074	<u>Licenses, Inspections &amp; Permits</u>	1,221	
				<u>Pension Expense</u>	40,393	<u>Advertising &amp; Promotions</u>	11,722	
				<u>Other Employee Welfare</u>	3,156	<u>Alloc from Extended Care Consulting</u>	2,977	
				<u>Holiday Expense</u>	3,025	<u>See Supplemental Schedule</u>	167	
						Less: <u>Public Relations Expense</u>	( )	
						<u>Non-allowable advertising</u>	(11,722)	
						<u>Yellow page advertising</u>	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 177,706	TOTAL (agree to Schedule V, line 22, col.8)	\$ 457,385	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 10,901	
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
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	Seminar Expense	6,193
							<u>Allocated From EC Consulting</u>	145
							<u>Allocated From EC Clinical</u>	1,337
							<u>Entertainment Expense</u>	( )
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 450,437				TOTAL	\$ 7,675

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Hillcrest Nursing &amp; Rehab Center

# 0050690

Report Period Beginning:

01/01/10

Ending:

12/31/10

**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. N/A
- (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? N/A
- (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? N/A
- (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 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 6,299 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. N/A
- (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. #0037572
- (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. \$ N/A Has any meal income been offset against related costs?        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. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
- 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: N/A
- (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.