

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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

I. IDPH License ID Number: <u>0050690</u>			II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																		
Facility Name: <u>Hillcrest Nursing & Rehab Center, LLC</u>			I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/11</u> to <u>12/31/11</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																																		
Address: <u>777 Draper Avenue</u> <u>Joliet</u> <u>60432</u> Number City Zip Code																																																					
County: <u>Will</u>																																																					
Telephone Number: <u>(815) 727 - 4794</u> Fax # <u>(815) 727 - 1026</u>																																																					
HFS ID Number: _____																																																					
Date of Initial License for Current Owners: <u>12/16/09</u>			Officer or Administrator of Provider (Signed) _____ (Type or Print Name) _____ (Title) _____ (Signed) _____ (Date) _____																																																		
Type of Ownership:																																																					
<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code _____</td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☒</td><td>Limited Liability Co.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Other</td><td colspan="2">_____</td></tr></table>			☐	VOLUNTARY, NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code _____		☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.	_____				☒	Limited Liability Co.	_____				☐	Trust					☐	Other	_____		Paid Preparer (Print Name and Title) <u>Edward N. Slack, CPA</u> <u>Partner, Health and Human Services</u> (Firm Name & Address) <u>Plante & Moran, PLLC</u> <u>2155 Point Boulevard, Suite 200 Elgin, Illinois 60123</u> (Telephone) <u>(847) 628 - 8796</u> Fax # <u>(248) 327 - 8417</u>		
☐	VOLUNTARY, NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL																																																
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		☐	Trust																																																		
		☐	Other	_____																																																	
In the event there are further questions about this report, please contact: Name: <u>Edward N. Slack, CPA</u> Telephone Number: <u>(847) 628 - 8796</u> Email Address: _____																																																					
			MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																																																		

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Hillcrest Nursing & Rehab Center, LLC

#

0050690

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

N/A

	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	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF		203	2,107	2,310	8
9	SNF/PED					9
10	ICF	51,922			51,922	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	51,922	203	2,107	54,232	14

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

88.44%

SEE ACCOUNTANTS' COMPILATION REPORT

D. How many bed-hold days during this year were paid by the Department?

0

(Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

N/A

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

X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

NO

X

I. On what date did you start providing long term care at this location?

Date started

09/15/91

J. Was the facility purchased or leased after January 1, 1978?

YES

X

Date

09/15/91

NO

K. Was the facility certified for Medicare during the reporting year?

YES

X

NO

If YES, enter number of beds certified

84

and days of care provided

2,107

Medicare Intermediary

National Government Services

IV. ACCOUNTING BASIS

ACCRUAL

X

MODIFIED CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

NO

Tax Year:

12/31/11

Fiscal Year:

12/31/11

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

Facility Name & ID Number Hillcrest Nursing & Rehab Center, LLC # 0050690 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	211,450	28,809	12,591	252,850		252,850	(1,429)	251,421			1
2	Food Purchase		296,389		296,389		296,389	(993)	295,396			2
3	Housekeeping	208,791	34,174		242,965		242,965	(629)	242,336			3
4	Laundry	36,011	20,921		56,932		56,932	(565)	56,367			4
5	Heat and Other Utilities			156,896	156,896		156,896	1,004	157,900			5
6	Maintenance	88,248		99,359	187,607		187,607	10,513	198,120			6
7	Other (specify):* Supplemental	160,501			160,501		160,501	1,368	161,869			7
8	TOTAL General Services	705,001	380,293	268,846	1,354,140		1,354,140	9,269	1,363,409			8
	B. Health Care and Programs											
9	Medical Director			38,493	38,493		38,493		38,493			9
10	Nursing and Medical Records	1,856,879	81,981	9,337	1,948,197		1,948,197	(354)	1,947,843			10
10a	Therapy	119,235			119,235		119,235		119,235			10a
11	Activities	99,251	40,784		140,035		140,035		140,035			11
12	Social Services	357,294	20,008		377,302		377,302		377,302			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,432,659	142,773	47,830	2,623,262		2,623,262	(354)	2,622,908			16
	C. General Administration											
17	Administrative	154,227			154,227		154,227	13,267	167,494			17
18	Directors Fees											18
19	Professional Services			272,885	272,885		272,885	(148,082)	124,803			19
20	Dues, Fees, Subscriptions & Promotions			23,593	23,593		23,593	(10,368)	13,225			20
21	Clerical & General Office Expenses	123,771	20,229	203,633	347,633		347,633	(57,793)	289,840			21
22	Employee Benefits & Payroll Taxes			593,980	593,980		593,980	(6,318)	587,662			22
23	Inservice Training & Education			675	675		675		675			23
24	Travel and Seminar			2,138	2,138		2,138	186	2,324			24
25	Other Admin. Staff Transportation			22,582	22,582		22,582	474	23,056			25
26	Insurance-Prop.Liab.Malpractice			113,050	113,050		113,050	897	113,947			26
27	Other (specify):* Supplemental							21,490	21,490			27
28	TOTAL General Administration	277,998	20,229	1,232,536	1,530,763		1,530,763	(186,247)	1,344,516			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,415,658	543,295	1,549,212	5,508,165		5,508,165	(177,332)	5,330,833			29

*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.

Page 3 Supplemental Schedule - Other Admin. Staff Transportation

HFS 3745 (N-4-99)

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			7,471	7,471		7,471	225,210	232,681			30
31	Amortization of Pre-Op. & Org.			4,281	4,281		4,281		4,281			31
32	Interest							509,571	509,571			32
33	Real Estate Taxes							89,565	89,565			33
34	Rent-Facility & Grounds			833,166	833,166		833,166	(829,712)	3,454			34
35	Rent-Equipment & Vehicles			44,101	44,101		44,101	3,675	47,776			35
36	Other (specify):*											36
37	TOTAL Ownership			889,019	889,019		889,019	(1,691)	887,328			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		213,105	299,540	512,645		512,645	(53,151)	459,494			39
40	Barber and Beauty Shops			336	336		336		336			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			323,678	323,678		323,678		323,678			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		213,105	623,554	836,659		836,659	(53,151)	783,508			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,415,658	756,400	3,061,785	7,233,843		7,233,843	(232,174)	7,001,669			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

Facility Name & ID Number Hillcrest Nursing & Rehab Center, LLC# 0050690Report Period Beginning: 01/01/11Ending: 12/31/11**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.)**

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 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
10	Interest and Other Investment Income	(24,139)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,265)	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	(273)	21		18
19	Entertainment				19
20	Contributions	(500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(142,973)	21		24
25	Fund Raising, Advertising and Promotional	(13,240)	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 <u>See Supplemental</u>	(78,662)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (261,052)		\$	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 Amount	2 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)	28,878		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 28,878		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (232,174)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	<u>Gift and Coffee Shops</u>					40
41	<u>Barber and Beauty Shops</u>					41
42	<u>Laboratory and Radiology</u>					42
43	<u>Prescription Drugs</u>					43
44						44
45	<u>Other-Attach Schedule</u>					45
46	<u>Other-Attach Schedule</u>					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

BHF USE ONLY							
48		49		50		51	

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Jury Duty Income	\$ (20)	10	1
2	Other Income	(3,387)	21	2
3	Bank Charges	(27,966)	21	3
4	Theft Loss	(401)	21	4
5	Collection Fees	(71)	21	5
6	TAG Properties - Office Space	(20,915)	34	6
7	Non-Allowable Legal	(14,092)	19	7
8	TAG Properties - Other Professional	(1,620)	19	8
9				9
10				10
11				11
12				12
13	Hillcrest Realty, LLC			13
14	Bank Service Fees	(367)	21	14
15	Filing Fees	(250)	21	15
16	Amortization	(9,573)	31	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(78,662)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hillcrest Nursing & Rehab Center, LLC # 0050690 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	283	0	0	0	0	(1,712)	0	0	0	(1,429)	1
2	Food Purchase	(1,265)	0	272	0	0	0	0	0	0	0	0	(993)	2
3	Housekeeping	0	0	572	0	(1,201)	0	0	0	0	0	0	(629)	3
4	Laundry	0	0	0	0	(565)	0	0	0	0	0	0	(565)	4
5	Heat and Other Utilities	0	0	1,004	0	0	0	0	0	0	0	0	1,004	5
6	Maintenance	0	0	2,883	7,630	0	0	0	0	0	0	0	10,513	6
7	Other (specify):*	0	0	0	1,368	0	0	0	0	0	0	0	1,368	7
8	TOTAL General Services	(1,265)	0	5,014	8,998	(1,766)	0	0	(1,712)	0	0	0	9,269	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(20)	0	0	0	(334)	0	0	0	0	0	0	(354)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(20)	0	0	0	(334)	0	0	0	0	0	0	(354)	16
	C. General Administration													
17	Administrative	0	0	3,012	10,255	0	0	0	0	0	0	0	13,267	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(15,712)	0	(132,370)	0	0	0	0	0	0	0	0	(148,082)	19
20	Fees, Subscriptions & Promotions	(13,740)	0	3,372	0	0	0	0	0	0	0	0	(10,368)	20
21	Clerical & General Office Expenses	(175,688)	617	12,489	104,827	0	0	0	(38)	0	0	0	(57,793)	21
22	Employee Benefits & Payroll Taxes	0	0	0	(6,318)	0	0	0	0	0	0	0	(6,318)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	186	0	0	0	0	0	0	0	0	186	24
25	Other Admin. Staff Transportation	0	0	474	0	0	0	0	0	0	0	0	474	25
26	Insurance-Prop.Liab.Malpractice	0	0	897	0	0	0	0	0	0	0	0	897	26
27	Other (specify):*	0	0	0	21,490	0	0	0	0	0	0	0	21,490	27
28	TOTAL General Administration	(205,140)	617	(111,940)	130,254	0	0	0	(38)	0	0	0	(186,247)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(206,425)	617	(106,926)	139,252	(2,100)	0	0	(1,750)	0	0	0	(177,332)	29

Summary B

12/31/11

												SUMMARY	
Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
Depreciation	0	215,515	9,695	0	0	0	0	0	0	0	0	225,210	30
Amortization of Pre-Op. & Org.	(9,573)	9,573	0	0	0	0	0	0	0	0	0	0	31
Interest	(24,139)	525,464	8,246	0	0	0	0	0	0	0	0	509,571	32
Real Estate Taxes	0	88,078	1,487	0	0	0	0	0	0	0	0	89,565	33
Rent-Facility & Grounds	(20,915)	(808,797)	0	0	0	0	0	0	0	0	0	(829,712)	34
Rent-Equipment & Vehicles	0	0	3,675	0	0	0	0	0	0	0	0	3,675	35
Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
TOTAL Ownership	(54,627)	29,833	23,103	0	0	0	0	0	0	0	0	(1,691)	37
Ancillary Expense													
E. Special Cost Centers													
Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
Ancillary Service Centers	0	0	0	0	(1,388)	0	(49,678)	(898)	(1,187)	0	0	(53,151)	39
Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
TOTAL Special Cost Centers	0	0	0	0	(1,388)	0	(49,678)	(898)	(1,187)	0	0	(53,151)	44
GRAND TOTAL COST (sum of lines 29, 37 & 44)	(261,052)	30,450	(83,823)	139,252	(3,488)	0	(49,678)	(2,648)	(1,187)	0	0	(232,174)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1OWNERS		2RELATED NURSING HOMES		3OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6 - Supp		See Page 6 - Supp		See Page 6 - Supp		

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.

1Schedule V		2Line	3Cost Per General LedgerItem	4Amount	5Cost to Related OrganizationName of Related Organization	6Percent of Ownership	7Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$808,797	Hillcrest Realty, LLC	100.00%	\$	(808,797)	1
2	V	21	Bank Service Fees		Hillcrest Realty, LLC	100.00%	367	367	2
3	V	21	Filing Fees		Hillcrest Realty, LLC	100.00%	250	250	3
4	V	30	Depreciation		Hillcrest Realty, LLC	100.00%	215,515	215,515	4
5	V	31	Amortization		Hillcrest Realty, LLC	100.00%	9,573	9,573	5
6	V	32	Interest		Hillcrest Realty, LLC	100.00%	525,464	525,464	6
7	V	33	Real Estate Taxes		Hillcrest Realty, LLC	100.00%	88,078	88,078	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$808,797			\$839,247	\$ *30,450	14

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Hillcrest Nursing & Rehab Center, LLC

0050690

Report Period Beginning:

01/01/11

Ending:

12/31/11

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Eric Rothner	90.00%	Avenue Care Nursing and Rehab	Chicago, IL	Ext. Care Consult.	Evanston, IL	Home Office	1
2	Rothner Family Grandchildren Trust	10.00%	Beecher Manor Nursing and Rehab	Beecher, IL	Ext. Care Clinical	Evanston, IL	Administrative	2
3			Briar Place	Indian Head, IL	CC Health Systems	Des Plaines, IL	Dietary & Suppl.	3
4			Chateau Village Nursing and Rehab	Willowbrook, IL	CCS VEBA	Evanston, IL	Health Insurance	4
5			Grasmere Place	Chicago, IL	Xcel Medical Supply	Evanston, IL	Medical Supplies	5
6			Lakewood Nursing and Rehab	Plainfield, IL	Rothner Vents	Evanston, IL	Vent. Rental	6
7			Lemont Nursing and Rehab	Lemont, IL	Tricare Rehab	Hillside, IL	Therapy	7
8			Prairie Manor Halth Care	Chicago Heights, IL	Reliable Medical	Des Plaines, IL	Medical Supplies	8
9			Rainbow Beach Nursing Center	Chicago, IL	Harbor Light	Glen Ellyn, IL	Hospice	9
10			Sheridan Shores	Chicago, IL	2201 Main	Evanston, IL	Bldg. Company	10
11			Snow Vally Nursing and Rehab	Lisle, IL				11
12			South Suburban Rehabilitation Center	Chicago, IL	Hillcrest			12
13			Tri-State Nursing and Rehab	Lansing, IL	Realty, LLC	Joliet, IL	Bldg. Company	13
14			Wheaton Care Center	Wheaton, IL				14
15			Boulevard Care Nursing and Rehab	Chicago, IL				15
16			Countryside Nursing and Rehab	Dolton, IL				16
17			Hillcrest Nursing and Rehab	Joliet, IL				17
18			Oak Park Healthcare Center	Oak Park, IL				18
19			Park House Nursing and Rehab	Chicago, IL				19
20			Timber Point Healthcare Center	Camp Point, IL				20
21			Prairie Village Healthcare Center	Jacksonville, IL				21
22			Dyer Nursing and Rehab	Dyer, IN				22
23			Lake County Nursing and Rehab	East Chicago, IN				23
24			Sebos Nursing and Rehab	Holbart, IN				24
25			Sheffield Manor Healthcare	Indianapolis, IN				25
26			McKinley Health Care Center	Canton, OH				26
27			Homestead Nursing and Rehab	Lincoln, NE				27
28			Lancaster Manor	Lincoln, NE				28
29			Golden Plaines	Hutchinson, KS				29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

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%	\$ 283	\$ 283	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	272	272	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	572	572	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	1,004	1,004	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	2,883	2,883	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	3,012	3,012	20
21	V	19	Professional Fees	138,000	Extended Care Consulting, LLC	100.00%	5,630	(132,370)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	3,372	3,372	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	12,489	12,489	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	186	186	24
25	V	25	Other Staff Admin. Transport.		Extended Care Consulting, LLC	100.00%	474	474	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	897	897	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	9,695	9,695	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	8,246	8,246	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,487	1,487	29
30	V	35	Rent - Equipment and Auto		Extended Care Consulting, LLC	100.00%	3,675	3,675	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			\$ 138,000			\$ 54,177	\$ * (83,823)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$	Extended Care Consulting, LLC	100.00%	\$ 7,630	\$ 7,630	15
16	V	06	Maintenance		Extended Care Consulting, LLC	100.00%			16
17	V	07	Employee Benefits		Extended Care Consulting, LLC	100.00%	1,368	1,368	17
18	V	07	Employee Benefits		Extended Care Consulting, LLC	100.00%			18
19	V	17	Administrative		Extended Care Consulting, LLC	100.00%	10,255	10,255	19
20	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	104,826	104,826	20
21	V	21	Office and Clerical	16,250	Extended Care Consulting, LLC	100.00%	16,251	1	21
22	V	27	Employee Benefits		Extended Care Consulting, LLC	100.00%	19,801	19,801	22
23	V	27	Employee Benefits		Extended Care Consulting, LLC	100.00%	1,689	1,689	23
24	V	22	Employee Benefits	6,318	Extended Care Consulting, LLC	100.00%		(6,318)	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			\$ 22,568			\$ 161,820	\$ * 139,252	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$	Xcel Supply, LLC	100.00%	\$		15
16	V	03	Housekeeping	19,814	Xcel Supply, LLC	100.00%	18,613	(1,201)	16
17	V	04	Laundry	9,332	Xcel Supply, LLC	100.00%	8,767	(565)	17
18	V	06	Repairs and Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10	Nursing	5,504	Xcel Supply, LLC	100.00%	5,170	(334)	19
20	V	11	Activities		Xcel Supply, LLC	100.00%			20
21	V	21	Office and Clerical		Xcel Supply, LLC	100.00%			21
22	V	22	Employee Benefits		Xcel Supply, LLC	100.00%			22
23	V	30	Depreciation		Xcel Supply, LLC	100.00%			23
24	V	39	Ancillary	22,901	Xcel Supply, LLC	100.00%	21,513	(1,388)	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			\$ 57,551			\$ 54,063	\$ * (3,488)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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.

☒ X

 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	Health Insurance	\$ 92,761	CCS VEBA	100.00%	\$ 92,761	\$	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			\$ 92,761			\$ 92,761	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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.

☒ X

 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	\$ 296,047	Tricare Rehab	100.00%	\$ 246,369	\$ (49,678)	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			\$ 296,047			\$ 246,369	\$ * (49,678)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 3,572	Care Centers Health Systems, Inc.	100.00%	\$ 1,860	\$ (1,712)	15
16	V	21	Office and Clerical	79	Care Centers Health Systems, Inc.	100.00%	41	(38)	16
17	V	39	Ancillary	1,873	Care Centers Health Systems, Inc.	100.00%	975	(898)	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			\$ 5,524			\$ 2,876	\$ * (2,648)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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.

☒ X

 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	Ancillary	\$ 1,800	Vent Lease, LLC	100.00%	\$ 613	\$ (1,187)	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			\$ 1,800			\$ 613	\$ * (1,187)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hillcrest Nursing & Rehab Center, LLC # 0050690 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	Adam Vales	Relative	Clerical		See Attached	0.55	0.01	Alloc. Sal	\$ 981	22 - 7	1
2	G. Matt Silvers	Relative	Administrative		See Attached	0.18	0.00	Alloc. Sal	721	17 - 7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 1,702		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, LLC # 0050690 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 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						\$	\$			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					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hillcrest Nursing & Rehab Center, LLC # 0050690 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization Extended Care Consulting, LLC
Street Address 2201 Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847) 905 - 3000
Fax Number (847) 491 - 9565

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	1,332,501	31	\$ 6,942	\$	54,232	\$ 283	1
2	02	Food	Patient Days	1,332,501	31	6,677		54,232	272	2
3	03	Housekeeping	Patient Days	1,332,501	31	14,059		54,232	572	3
4	05	Utilities	Patient Days	1,332,501	31	24,674		54,232	1,004	4
5	06	Maintenance	Patient Days	1,332,501	31	70,833		54,232	2,883	5
6	17	Administrative	Patient Days	1,332,501	31	74,000		54,232	3,012	6
7	19	Professional Fees	Patient Days	1,332,501	31	138,332		54,232	5,630	7
8	20	Dues and Subscriptions	Patient Days	1,332,501	31	82,842		54,232	3,372	8
9	21	Office and Clerical	Patient Days	1,332,501	31	306,863		54,232	12,489	9
10	24	Seminar and Travel	Patient Days	1,332,501	31	4,580		54,232	186	10
11	25	Other Staff Admin. Transpor.	Patient Days	1,332,501	31	11,637		54,232	474	11
12	26	Insurance	Patient Days	1,332,501	31	22,043		54,232	897	12
13	30	Depreciation	Patient Days	1,332,501	31	238,204		54,232	9,695	13
14	32	Interest	Patient Days	1,332,501	31	202,602		54,232	8,246	14
15	33	Real Estate Taxes	Patient Days	1,332,501	31	36,524		54,232	1,487	15
16	35	Rent - Equipment and Auto	Patient Days	1,332,501	31	90,286		54,232	3,675	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,331,098	\$		\$ 54,177	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hillcrest Nursing & Rehab Center, LLC # 0050690 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Extended Care Consulting, LLC
Street Address 2201 Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847) 905 - 3000
Fax Number (847) 491 - 9565

	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	06	Maintenance	Patient Days	1,332,501	31	\$ 187,474	\$ 187,474	54,232	\$ 7,630	1
2	06	Maintenance	Direct Allocation	1	1			1		2
3	07	Employee Benefits	Patient Days	1,332,501	31	33,619		54,232	1,368	3
4	07	Employee Benefits	Direct Allocation	1	1			1		4
5	17	Administrative	Patient Days	1,332,501	31	251,959	251,959	54,232	10,255	5
6	21	Office and Clerical	Patient Days	1,332,501	31	2,575,611	2,575,611	54,232	104,826	6
7	21	Office and Clerical	Direct Allocation	1	1	16,251	16,251	1	16,251	7
8	27	Employee Benefits	Patient Days	1,332,501	31	486,522		54,232	19,801	8
9	27	Employee Benefits	Direct Allocation	1	1	1,689		1	1,689	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					\$ 3,553,125	\$ 3,031,295		\$ 161,820	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hillcrest Nursing & Rehab Center, LLC # 0050690 Report Period Beginning: 01/01/11 Ending: 12/31/11

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, Illinois 60202
Phone Number (847) 328 - 7600
Fax Number ()

	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	01	Dietary	Direct Allocation	1	1	\$	\$	1	\$	1
2	03	Housekeeping	Direct Allocation	1	1	18,613		1	18,613	2
3	04	Laundry	Direct Allocation	1	1	8,767		1	8,767	3
4	06	Repairs and Maintenance	Direct Allocation	1	1			1		4
5	10	Nursing	Direct Allocation	1	1	5,170		1	5,170	5
6	11	Activities	Direct Allocation	1	1			1		6
7	21	Office and Clerical	Direct Allocation	1	1			1		7
8	22	Employee Benefits	Direct Allocation	1	1			1		8
9	30	Depreciation	Direct Allocation	1	1			1		9
10	39	Ancillary	Direct Allocation	1	1	21,513		1	21,513	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					\$ 54,063	\$		\$ 54,063	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hillcrest Nursing & Rehab Center, LLC # 0050690 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 VEBA
Street Address 2201 Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847) 905 - 3000
Fax Number (847) 491 - 9565

	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	Health Insurance	Direct Allocation	1	1	\$ 92,761	\$	1	\$ 92,761	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					\$ 92,761	\$		\$ 92,761	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hillcrest Nursing & Rehab Center, LLC # 0050690 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Tricare Rehab
Street Address 150 Fencil Lane
City / State / Zip Code Hillside, Illinois 60162
Phone Number (708) 449 - 9400
Fax Number (708) 449 - 9700

	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	39	Therapy	Direct Allocation	1	1	\$ 246,369	\$	1	\$ 246,369	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					\$ 246,369	\$		\$ 246,369	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hillcrest Nursing & Rehab Center, LLC # 0050690 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 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

	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	01	Dietary	Direct Allocation	1	1	\$ 1,860	\$	1	\$ 1,860	1
2	21	Office and Clerical	Direct Allocation	1	1	41		1	41	2
3	39	Ancillary	Direct Allocation	1	1	975		1	975	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					\$ 2,876	\$		\$ 2,876	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hillcrest Nursing & Rehab Center, LLC # 0050690 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Vent Lease, LLC
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	39	Ancillary	Direct Allocation	1	1	\$ 613	\$	1	\$ 613	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					\$ 613	\$		\$ 613	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1	Lake Forest		X	Mortgage			\$	5,603,047			\$ 525,464	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Extended Care Consulting	X		Line of Credit							8,246	6
7												7
8												8
9	TOTAL Facility Related						\$	5,603,047			\$ 533,710	9
	B. Non-Facility Related*											
10	Interest Income		X								(24,139)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$				\$ (24,139)	14
15	TOTALS (line 9+line14)						\$	5,603,047			\$ 509,571	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 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.)

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 2010 report.				\$	78,8001																				
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.)				\$	82,8892																				
3. Under or (over) accrual (line 2 minus line 1).				\$	4,0893																				
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	85,4734																				
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	5																				
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	6																				
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	89,5627																				
Real Estate Tax History:																									
Real Estate Tax Bill for Calendar Year:		2006	71,733	8	<table><tr><td></td><td colspan="2">FOR BHF USE ONLY</td><td></td></tr><tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2010</td><td>\$</td><td>13</td></tr><tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr><tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr><tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr></table>		FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2010	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
	FOR BHF USE ONLY																								
13	FROM R. E. TAX STATEMENT FOR 2010	\$	13																						
14	PLUS APPEAL COST FROM LINE 5	\$	14																						
15	LESS REFUND FROM LINE 6	\$	15																						
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																						
		2007	71,559	9																					
		2008	72,380	10																					
		2009	75,048	11																					
		2010	81,402	12																					
2011 Tax Accrual = \$81,402 * 1.05 = \$85,473																									
Extended Care Consulting, LLC (Allocation) - \$1,487																									

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

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Hillcrest Nursing & Rehab Center, LLC COUNTY Will

FACILITY IDPH LICENSE NUMBER 0050690

CONTACT PERSON REGARDING THIS REPORT Edward N. Slack

TELEPHONE (847) 628 - 8796 FAX #: (847) 327 - 8417

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 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 2010.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 30-07-11-101-003-0000	Long Term Care Facility	\$ 81,402.48	\$ 81,402.48
2. Allocation	Extended Care Consulting, LLC	\$ 126,481.18	\$ 2,075.31
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 207,883.66	\$ 83,477.79

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? X YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

X. BUILDING AND GENERAL INFORMATION:

- A. Square Feet: 23,039
- B. General Construction Type: Exterior Brick Frame Steel
- Number of Stories 3
- C. Does the Operating Entity? (a) Own the Facility (X) (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? (X) (a) Own the Equipment (X) (b) Rent equipment from a Related Organization. (X) (c) Rent equipment from Completely Unrelated Organization.
- (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)
- E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

- F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES (X) 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	Facility			\$ 336,000	1
2	Ext. Care Consult.			13,455	2
3	TOTALS			\$ 349,455	3

SEE ACCOUNTANTS' COMPILATION REPORT

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

Report Period Beginning:

01/01/11

Ending:

12/31/11**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1991	6,230						9
10	Various			1992	48,072						10
11	Various			1993	33,291						11
12	Various			1994	10,172						12
13	Various			1995	5,221						13
14	Various			1996	13,337						14
15	Various			1997	4,650						15
16	Various			1998	191,229						16
17	Various			1999	70,751						17
18	Various			2000	14,257						18
19	Various			2001	95,777						19
20	Various			2002	16,919						20
21	Various			2003	174,878						21
22	Various			2004	7,188						22
23	Various			2005	120,877						23
24	Various			2006	36,114						24
25	Various			2007	54,833						25
26	Demolition, Framing, Insulation, Drywall, Tile, Baseboard, Etc.			2008	136,414						26
27	Elevator, Doors, A/C, Ductwork, Sprinkler System			2008	238,390						27
28	Blacktop, Sidewalk, Patio, Concrete Benches			2008	20,200						28
29	Roof Deck, Soffit, Sprinkler Heads, Toilets, Doors			2009	19,110						29
30	Kitchen Piping and Wiring			2009	8,272	226		226		479	30
31	Sidewalk Renovations			2010	4,750	173		173		309	31
32	Security Systems- Replace VDR and 7 Cameras			2010	3,600	131		131		235	32
33	Replace Water Heater			2010	2,585	94		94		153	33
34	Replace Main Lighting and Heating Circuit Breakers			2010	14,400	524		524		807	34
35	Replace Kitchen Heating and Cooling Unit			2010	7,100	258		258		398	35
36	Electrical Work for Four Rooms on 2nd Floor and Main Dining			2010	4,150	151		151		208	36

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

See Page 12A, Line 70 for total

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

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	Shingle, Drain and Downspout Replacement	2010	\$ 10,380	\$ 377		\$ 377	\$	\$ 487	37
38	Duro Last Drains	2010	3,400	124		124		139	38
39	Painting	2010	15,831						39
40	5 PTAC Type Air Conditioning Units	2010	3,288						40
41	Remove and Replace Generator	2010	7,500						41
42	6 PTAC Type Air Conditioning Units	2010	3,476						42
43	Ceiling in Dining Room	2011	3,275	119		119		119	43
44	Roof Repair	2011	7,650	128		128		128	44
45	Office Area Ductwork	2011	3,274	14		14		14	45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,420,841	\$ 2,319		\$ 2,319	\$	\$ 3,476	70

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 and Improvement Costs-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	Totals from Page 12A, Carried Forward		\$ 1,420,841	\$ 2,319		\$ 2,319	\$	\$ 3,476	1
2									2
3	Related Party Allocations - See Supplemental Schedules								3
4									4
5	Hillcrest Realty, LLC - Building	1976	5,288,000	192,291	27.5	192,291		854,038	5
6									6
7	Allocations - Extended Care Consulting	2007	187	9		9		47	7
8	Allocations - Extended Care Consulting	2009	112	6		6		17	8
9	Allocations - Extended Care Consulting	2010	1,098	55		55		110	9
10	Allocations - Extended Care Consulting	2011	395	20		20		20	10
11									11
12	Allocations - Extended Care Consulting / 2201 Main LLC	2002	18,541	475		475		4,417	12
13	Allocations - Extended Care Consulting / 2201 Main LLC	2002	15,316	1,400		1,400		11,211	13
14	Allocations - Extended Care Consulting / 2201 Main LLC	2003	18,050	1,650		1,650		13,212	14
15	Allocations - Extended Care Consulting / 2201 Main LLC	2005	897	95		95		514	15
16	Allocations - Extended Care Consulting / 2201 Main LLC	2009	162	8		8		24	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)		\$ 6,763,599	\$ 198,328		\$ 198,328	\$	\$ 887,086	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$19,348	\$3,871	\$3,871	\$	5 - 7	\$6,046	71
72	Current Year Purchases	12,544	1,283	1,283		5 - 7	1,283	72
73	Fully Depreciated Assets							73
74	See Supplemental	504,299	28,995	28,995		5	461,485	74
75	TOTALS	\$536,191	\$34,149	\$34,149	\$		\$468,814	75

D. Vehicle Costs. (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	Extended Care Consulting			\$13,087	\$204	\$204	\$	5	\$12,883	76
77										77
78										78
79										79
80	TOTALS			\$13,087	\$204	\$204	\$		\$12,883	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)	\$7,662,332	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$232,681	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$232,681	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,368,783	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.

Hillcrest Nursing & Rehab Center, LLC
Medicaid Cost Report
01/01/11 - 12/31/11

Page 13 Supplemental Schedule

Description	Cost	Depreciation	Accumulated Depreciation
Related Party 1 - Hillcrest Realty, LLC			
Prior	336,000	23,224	301,163
Current			
Total	336,000	23,224	301,163
Related Party 2 - Extended Care Consulting			
Prior	119,435	407	116,535
Current	133	13	13
Total	119,568	420	116,548
Related Party 3 - Extended Care Consulting / 2201 Mail LLC			
Prior	5,134	513	4,561
Current			
Total	5,134	513	4,561
Related Party 4 - Extended Care Consulting - Matrix Software			
Prior	43,597	4,838	39,213
Current			
Total	43,597	4,838	39,213
Total	504,299	28,995	461,485

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								5
6	See Supp.				3,454			6
7	TOTAL				\$3,454			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

XNO
16. Rental Amount for movable equipment: \$38,786Description:

See Supplemental 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	Acura	\$	\$8,990	17
18					18
19					19
20					20
21	TOTAL		\$	\$8,990	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. /2012\$

13. /2013\$

14. /2014\$
- * 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.
- SEE ACCOUNTANTS' COMPILATION REPORT
- HFS 3745 (N-4-99)
- IL478-2471

Hillcrest Nursing & Rehab Center, LLC
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Page 14 Supplemental Schedule - Building Rental

Vendor	Description	Amount
Care Consultants of Illinois	Off-Site Storage Rental	3,454
TAG Properties	Office Space	20,916
TAG Properties	Office Space - Non Allowable	(20,916)
Total		<u>3,454</u>

Page 14 Supplemental Schedule - Equipment Rental

Vendor	Description	Amount
GE Capital	Copier	8,757
Hughes Enterprises	Medical Equipment	9,000
Vent Lease	Medical Equipment	750
Hasler	Medical Equipment	267
Global Medical	Medical Equipment	5,214
Care Consultants of Illinois	Medical Equipment	466
Fleet Services	Various Rentals	10,657
Alloc. - Extended Care Consulting		3,675
Total		<u>38,786</u>

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

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

- (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.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (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.)

		1	2	3	4	5	6	7	8	
	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	\$		\$ 149,846	\$		\$ 149,846	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			14,485			14,485	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			131,716			131,716	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				138,464		138,464	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					74,641		74,641	12
13	Other (specify): See Supplemental	39 - 03				3,493			3,493	13
14	TOTAL			\$		\$ 299,540	\$ 213,105		\$ 512,645	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

Page 16 Supplemental Schedule

IL478-2471

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$ 129	1
2	Cash-Patient Deposits	38,085	38,085	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 311,908)	3,175,928	3,175,928	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	63,001	63,001	6
7	Other Prepaid Expenses	18,900	18,900	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental	1,154	135,211	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,297,068	\$ 3,431,254	10
	B. Long-Term Assets			
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	70,768	70,768	15
16	Equipment, at Historical Cost	31,892	367,892	16
17	Accumulated Depreciation (book methods)	(10,805)	(1,166,006)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental		38,097	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 91,855	\$ 4,934,751	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,388,923	\$ 8,366,005	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,462,213	\$ 1,462,213	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,862	17,862	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	160,152	160,152	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		85,473	32
33	Accrued Interest Payable		22,636	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental	335,827		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,976,054	\$ 1,748,336	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,603,047	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 5,603,047	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,976,054	\$ 7,351,383	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,412,869	\$ 1,014,622	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,388,923	\$ 8,366,005	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Page 17 Supplemental Schedule

HFS 3745 (N-4-99)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 932,424	1
2	Restatements (describe):		2
3	Post Cost Report Accounting Adjustments	(40,500)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 891,924	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	520,945	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 520,945	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,412,869	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,565,039	1
2	Discounts and Allowances for all Levels	(765,951)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,799,088	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	816,933	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 816,933	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	101,645	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	3,922	20
21	Other Medical Services	5,654	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 111,221	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	24,139	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 24,139	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	3,407	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,407	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,754,788	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,354,140	31
32	Health Care	2,623,262	32
33	General Administration	1,530,763	33
	B. Capital Expense		
34	Ownership	889,019	34
	C. Ancillary Expense		
35	Special Cost Centers	512,981	35
36	Provider Participation Fee	323,678	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,233,843	40
41	Income before Income Taxes (line 30 minus line 40)**	520,945	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 520,945	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Finished 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.

Page 19 Supplemental Schedule

IL478-2471

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,958	2,154	\$ 100,612	\$ 46.71	1
2	Assistant Director of Nursing	3,298	3,566	209,660	58.79	2
3	Registered Nurses	12,180	13,160	379,327	28.82	3
4	Licensed Practical Nurses	25,398	26,982	648,757	24.04	4
5	CNAs & Orderlies	45,487	49,371	488,607	9.90	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,596	7,784	119,235	15.32	8
9	Activity Director	1,950	2,137	32,275	15.10	9
10	Activity Assistants	7,381	7,898	66,976	8.48	10
11	Social Service Workers	18,843	20,093	357,294	17.78	11
12	Dietician					12
13	Food Service Supervisor	1,839	2,012	44,612	22.17	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,674	6,077	56,821	9.35	15
16	Dishwashers	11,841	12,825	110,017	8.58	16
17	Maintenance Workers	5,087	5,431	88,248	16.25	17
18	Housekeepers	20,463	22,794	208,791	9.16	18
19	Laundry	3,293	3,707	36,011	9.71	19
20	Administrator	1,974	2,181	102,405	46.95	20
21	Assistant Administrator	2,031	2,131	51,822	24.32	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,347	6,900	123,771	17.94	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	2,076	2,277	29,916	13.14	31
32	Other Health Care(specify)					32
33	Other(specify) Supplemental	17,117	18,398	160,501	8.72	33
34	TOTAL (lines 1 - 33)	200,833	217,878	\$ 3,415,658 *	\$ 15.68	34

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	234	\$ 12,591	01 - 03	35
36	Medical Director	Monthly	38,493	09 - 03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	9,337	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)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	234	\$ 60,421		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

* This total must agree with page 4, column 1, line 45.

** See instructions.

Hillcrest Nursing & Rehab Center, LLC
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Description	Hours Worked	Hours Paid	Salary
Other Salaries			
Security	17,117	18,398	160,501
Total	17,117	18,398	160,501

XIX. SUPPORT SCHEDULES												
A. Administrative Salaries				Ownership			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name		Function	%	Amount	Description		Amount		Description		Amount	
Amy Sparks		Administrator	0	\$ 102,405	Workers' Compensation Insurance		\$ 104,602		IDPH License Fee		\$ 1,990	
Kevin Meals		Asst. Admin.	0	51,822	Unemployment Compensation Insurance		93,893		Advertising: Employee Recruitment		1,524	
					FICA Taxes		263,039		Health Care Worker Background Check		6,138	
					Employee Health Insurance		73,092		(Indicate # of checks performed 377)			
					Employee Meals				Patient Background Checks			
					Illinois Municipal Retirement Fund (IMRF)*				Dues and Subscriptions		157	
					Employee Physicals				Licenses and Fees		44	
					Holiday Expense		2,110		Advertising and Promotion		13,240	
					Pension		47,171		Alloc. - Extended Care Consulting		3,372	
					Other Employee Welfare		3,755					
									Less: Public Relations Expense		()	
									Non-allowable advertising		(13,240)	
									Yellow page advertising		()	
									TOTAL (agree to Sch. V,		\$ 13,225	
									line 20, col. 8)			
TOTAL (agree to Schedule V, line 17, col. 1)					TOTAL (agree to Schedule V,		\$ 587,662					
(List each licensed administrator separately.)				\$ 154,227	line 22, col.8)							
B. Administrative - Other					E. Schedule of Non-Cash Compensation Paid to Owners or Employees							
Description				Amount	Description		Line #	Amount	G. Schedule of Travel and Seminar**			
				\$				\$	Description			
									Amount			
									Out-of-State Travel			
									\$			
									In-State Travel			
									Seminar Expense			
									2,138			
									Alloc. - Extended Care Consulting			
									186			
									Entertainment Expense			
									()			
									(agree to Sch. V,			
									line 24, col. 8)			
TOTAL (agree to Schedule V, line 17, col. 3)					TOTAL			\$	TOTAL			
(If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 272,885					\$ 2,324			

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Hillcrest Nursing & Rehab Center, LLC
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Page 21 Supplemental Schedule - Other Professional Fees

Vendor	Type	Amount
Chad Cournaya	Other Professional	81
Faces Photography	Other Professional	1,000
Hamlin & Burton Liability	MSP Services	104
TAG Properties	Non-Allowable	1,620
Comcast Cable	Computer Maintenance	899
Care Consultants of Illinois	Computer Maintenance	14,551
OmniCare of Northern Illinois	Computer Maintenance	300
AT&T	Computer Maintenance	16
Care Consultants of Illinois	Other Professional	263
American Data	Data Processing	5,255
MDI Achieve	Data Processing	20,514
E Health Data Solutions	Data Processing	4,947
Medifax	Data Processing	216
Care Consultants of Illinois	Data Processing	448
Extended Care Consulting	Data Processing	6,946
Nebo Systems	Data Processing	79
National Datacare Corporation	Data Processing	3,318
Paycor	Data Processing	7,792
Pathlinks	Data Processing	3,592
Care Consultants of Illinois	Legal	1,819
Chuhak & Tecson	Legal	3,728
Extended Care Consulting	Legal	277
HFG	Legal	5,192
Law Office of Stephen N.	Legal	2,076
McVey & Parksy	Legal	1,000
Meyer Magence	Legal	12,054
		98,087

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Page 21 Supplemental Schedule - Legal Schedule

Vendor	Invoice Date	Amount	Allowable
Chuhak & Tecson, P.C.	01/31/11	792	
Chuhak & Tecson, P.C.	02/28/11	340	
Law Office Of Stephen N.	02/28/11	674	
Law Office Of Stephen N.	02/28/11	1,080	
Law Office Of Stephen N.	02/28/11	321	
Meyer Magence	02/28/11	1,660	1,660
Meyer Magence	02/28/11	803	803
Chuhak & Tecson, P.C.	03/31/11	108	
Meyer Magence	03/31/11	1,494	1,494
Chuhak & Tecson, P.C.	04/30/11	72	
Meyer Magence	04/30/11	188	188
Chuhak & Tecson, P.C.	05/31/11	180	
Chuhak & Tecson, P.C.	06/30/11	900	
Meyer Magence	06/30/11	500	500
Meyer Magence	06/30/11	3,799	3,799
Chuhak & Tecson, P.C.	08/31/11	396	
Chuhak & Tecson, P.C.	08/31/11	160	
Cc Of Il 12/10 Exp	09/30/11	816	
Cc Of Il Exp-Legal Fees K&L Gates	09/30/11	1,003	
Chuhak & Tecson, P.C.	09/30/11	72	
Chuhak & Tecson, P.C.	10/28/11	36	
Meyer Magence	10/28/11	1,556	1,556
Meyer Magence	10/28/11	1,368	1,368
Chuhak & Tecson, P.C.	10/31/11	5	
Chuhak & Tecson, P.C.	10/31/11	46	
Chuhak & Tecson, P.C.	10/31/11	324	
Meyer Magence	10/31/11	250	250
Meyer Magence	10/31/11	438	438
Mcvey & Parsky, Llc	11/15/11	1,000	
Chuhak & Tecson, P.C.	12/31/11	72	
Chuhak & Tecson, P.C.	12/31/11	142	
Chuhak & Tecson, P.C.	12/31/11	62	
Chuhak & Tecson, P.C.	12/31/11	10	
Chuhak & Tecson, P.C.	12/31/11	10	
Extended Care Consulting,	12/31/11	277	
HFG	Various	5,192	-
		26,146	12,054

Page 5 Adjustment

14,092

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Page 21 Supplemental Schedule - Seminar Schedule

Payee	Topic	Attendee	Location	Amount
Sierra Gabrys	IL Mental Health-Supervision Ethics	Sierra Gabrys		120
Sierra Gabrys	IMHCA Ethical Decision Making	Sierra Gabrys	Oak Brook, IL	120
Oakton Community College	36 Hour Basic Oreintation Course for Activity Directors	Richelle McKinney	Des Plaines, IL	450
Illinois Council On Long Term Care	The New Medicaid Integrated Care Program	Dr. Jakob Bakst	Oak Lawn, IL	105
Illinois Council On Long Term Care	The New Medicaid Integrated Care Program	Amy Sparks/Vicki Mattera/John Coglianese	Oak Lawn, IL	315
Illinois Council On Long Term Care	The Most Frequent Life Safety Code Violations	Dr. Jakob Bakst/ Amy Sparks/Kevin Meals	Oak Lawn & Skokie, IL	495
Sierra Gabrys	Psychopharmacology at CMI Premier Education	Sierra Gabrys	Tinley Park, IL	190
CC of IL/CMI Education Institute	My Mental Health Medication Book & Psychopharmacology Book	Books for Dr. Jakob Bakst	N/A	58
CC of IL/Ingenix, Inc.	ICD-9 Code Books for Skilled Nursing, Inpatient Rehab & Hospice		N/A	285
Alloc - Extended Care Consulting				186

2,324

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

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A

(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? 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

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