FOR BHF USE

LL1

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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0001099

Facility Name: Hillcrest Home

Address: 14688 Illinois Highway 82 (Number) Geneseo (City) 61254 (Zip Code)

County: Henry

Telephone Number: (309) 944 - 2147 **Fax #** (309) 944 - 8417

HFS ID Number:

Date of Initial License for Current Owners: 06/10/56

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	X	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Jeremy M. Brune, CPA **Telephone Number:** (779) 875 - 3979
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/01/11 to 11/30/12 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.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Mary Bergren
(Title) Administrator

Paid Preparer

(Signed) (Date)
(Print Name and Title) Jeremy M. Brune, CPA
(Firm Name & Address) Jeremy Brune & Associates, LLC
2508 Riverwalk Drive Plainfield, IL 60586
(Telephone) (779) 875 - 3979 Fax # (866) 216 - 5355

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 Home # 0001099 Report Period Beginning: 12/01/11 Ending: 11/30/12

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	106	Skilled (SNF)	106	38,796	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	106	TOTALS	106	38,796	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	17,314	17,645	1,819	36,778	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,314	17,645	1,819	36,778	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.80%

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 06/10/56

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 106 and days of care provided 1,300

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 11/30/12 Fiscal Year: 11/30/12

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/11 Ending: 11/30/12

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	303,887	19,411	6,968	330,266		330,266		330,266			1
2	Food Purchase		228,220		228,220		228,220	(4,335)	223,885			2
3	Housekeeping	71,945	3,847		75,792		75,792		75,792			3
4	Laundry	78,510	16,302		94,812		94,812		94,812			4
5	Heat and Other Utilities			102,095	102,095		102,095		102,095			5
6	Maintenance	84,786	30,109	81,959	196,854		196,854		196,854			6
7	Other (specify):*											7
8	TOTAL General Services	539,128	297,889	191,022	1,028,039		1,028,039	(4,335)	1,023,704			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	1,888,754	142,541	44,117	2,075,412		2,075,412		2,075,412			10
10a	Therapy	61,760			61,760		61,760		61,760			10a
11	Activities	66,758	5,476		72,234		72,234	(4,783)	67,451			11
12	Social Services	43,343		780	44,123		44,123		44,123			12
13	CNA Training											13
14	Program Transportation			2,941	2,941		2,941	(2,941)				14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,060,615	148,017	49,038	2,257,670		2,257,670	(7,724)	2,249,946			16
	C. General Administration											
17	Administrative	72,810			72,810		72,810		72,810			17
18	Directors Fees											18
19	Professional Services			4,578	4,578		4,578		4,578			19
20	Dues, Fees, Subscriptions & Promotions			10,610	10,610		10,610	(3,486)	7,124			20
21	Clerical & General Office Expenses	159,142	10,680	78,927	248,749		248,749	(37,677)	211,072			21
22	Employee Benefits & Payroll Taxes			953,537	953,537		953,537		953,537			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,783	3,783		3,783		3,783			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			62,491	62,491		62,491		62,491			26
27	Other (specify):*											27
28	TOTAL General Administration	231,952	10,680	1,113,926	1,356,558		1,356,558	(41,163)	1,315,395			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,831,695	456,586	1,353,986	4,642,267		4,642,267	(53,222)	4,589,045			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.

Facility Name & ID Number Hillcrest Home #0001099 Report Period Beginning: 12/01/11 Ending: 11/30/12

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			301,659	301,659		301,659	(25,825)	275,834			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			301,659	301,659		301,659	(25,825)	275,834			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	100,427	45,344	42,764	188,535		188,535		188,535			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			10,573	10,573		10,573	(10,573)				41
42	Provider Participation Fee			411,833	411,833		411,833		411,833			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	100,427	45,344	465,170	610,941		610,941	(10,573)	600,368			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,932,122	501,930	2,120,815	5,554,867		5,554,867	(89,620)	5,465,247			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 Home # 0001099 Report Period Beginning: 12/01/11 Ending: 11/30/12

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	(4,335)	02		4
5	Telephone, TV & Radio in Resident Rooms	(25)	21		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				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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				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	(37,577)	21		24
25	Fund Raising, Advertising and Promotional	(3,486)	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 Supplemental Schedule	(44,197)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (89,620)		$	30

BHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (89,620)		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	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	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Hillcrest Home

ID# 0001099

Report Period Beginning: 12/01/11

Ending: 11/30/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Concession Income - To Extent of Expense	$ (10,573)	41	1
2	Transportation Income - To Extent of Expense	(2,941)	14	2
3	Activity Income	(4,783)	11	3
4	Miscellaneous Income	(75)	21	4
5	Loss on Disposal of Assets	(25,825)	30	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(44,197)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hillcrest Home **#** 0001099 **Report Period Beginning:** 12/01/11 **Ending:** 11/30/12

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,335)	0	0	0	0	0	0	0	0	0	0	(4,335)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,335)	0	0	0	0	0	0	0	0	0	0	(4,335)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(4,783)	0	0	0	0	0	0	0	0	0	0	(4,783)	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	(2,941)	0	0	0	0	0	0	0	0	0	0	(2,941)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(7,724)	0	0	0	0	0	0	0	0	0	0	(7,724)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(3,486)	0	0	0	0	0	0	0	0	0	0	(3,486)	20
21	Clerical & General Office Expenses	(37,677)	0	0	0	0	0	0	0	0	0	0	(37,677)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(41,163)	0	0	0	0	0	0	0	0	0	0	(41,163)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(53,222)	0	0	0	0	0	0	0	0	0	0	(53,222)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Hillcrest Home # 0001099 **Report Period Beginning:** 12/01/11 **Ending:** 11/30/12

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(25,825)	0	0	0	0	0	0	0	0	0	0	(25,825)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(25,825)	0	0	0	0	0	0	0	0	0	0	(25,825)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	(10,573)	0	0	0	0	0	0	0	0	0	0	(10,573)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(10,573)	0	0	0	0	0	0	0	0	0	0	(10,573)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(89,620)	0	0	0	0	0	0	0	0	0	0	(89,620)	45

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/11 Ending: 11/30/12

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.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Henry County	100%					

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	22	FICA	$ 217,295	Henry County	100.00%	$ 217,295	$	1
2	V	22	IMRF	220,809	Henry County	100.00%	220,809		2
3	V	22	Workers Compensation	128,715	Henry County	100.00%	128,715		3
4	V	26	Property / Liability Insurance	62,266	Henry County	100.00%	62,266		4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 629,085			$ 629,085	$ *	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/11 Ending: 11/30/12

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	Board of Directors - Henry County							1
2								2
3	James Eccher	0.00%						3
4	Roger Gradert	0.00%						4
5	Rick Livesay	0.00%						5
6	Rebekah McCaw	0.00%						6
7	Pat Ripperger	0.00%						7
8	Dennis Sullivan	0.00%						8
9	Donald DeDobbelaere	0.00%						9
10	Tim Wells	0.00%						10
11	Dennis Anderson	0.00%						11
12	Kathy Nelson	0.00%						12
13	Kippy Nelson	0.00%						13
14	Bill Preston	0.00%						14
15	Tom Steele	0.00%						15
16	Karen Urick	0.00%						16
17	Muriel Weber	0.00%						17
18	Jon Zahm	0.00%						18
19	Ann DeSmith	0.00%						19
20	Jason DeSplinter	0.00%						20
21	James Kursock	0.00%						21
22	Jan May	0.00%						22
23	Jim Findley	0.00%						23
24	John Sovanski	0.00%						24
25	Ted Sturtevant	0.00%						25
26	Jerry Thompson	0.00%						26
27								27
28	There are no business transactions							28
29	between Henry County Board							29
30	Members and Hillcrest Home.							30

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/11 Ending: 11/30/12

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		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 Home # 0001099 Report Period Beginning: 12/01/11 Ending: 11/30/12

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 [X]

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 Home # 0001099 Report Period Beginning: 12/01/11 Ending: 11/30/12

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	N/A						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	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.)**

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/11 Ending: 11/30/12

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2007	8
	2008	9
	2009	10
	2010	11
	2011	12

N/A - County Nursing Home not subject to real estate taxes.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Hillcrest Home COUNTY Henry

FACILITY IDPH LICENSE NUMBER 0001099

CONTACT PERSON REGARDING THIS REPORT Jeremy M. Brune, CPA

TELEPHONE (779) 875 - 3979 FAX #: (866) 216 - 5355

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

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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 Home # 0001099 Report Period Beginning: 12/01/11 Ending: 11/30/12

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 67,394 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 3

C. Does the Operating Entity? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home		Various	$ 279,195	1
2					2
3	TOTALS			$ 279,195	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/11 Ending: 11/30/12

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	84		1971	1971	$ 220,795	$		$	$	$	4
5	22		1976	1976	1,064,182						5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1977	52,950						9
10	Various			1979	6,552						10
11	Various			1980	14,609						11
12	Various			1981	61,074						12
13	Various			1982	6,189						13
14	Various			1983	79,248						14
15	Various			1984	46,106						15
16	Various			1985	43,128						16
17	Various			1986	14,176						17
18	Various			1987	106,332						18
19	Various			1988	67,712						19
20	Various			1989	140,458						20
21	Various			1990	715,903						21
22	Various			1991	336,390						22
23	Various			1992	88,437						23
24	Various			1993	47,424						24
25	Various			1994	9,556						25
26	Various			1995	72,333						26
27	Various			1996	14,291						27
28	Various			1997	66,654						28
29	Various			1998	386,931						29
30	Various			1999	73,577						30
31	Various			2000	18,620						31
32	Various			2001	47,108						32
33	Various			2002	41,492						33
34	Various			2003	46,873						34
35	Various			2004	59,183						35
36	Various			2005	86,924						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

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/11 Ending: 11/30/12

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	
37	Various	2006	$ 143,409	$		$	$	$	37
38	Various	2007	610,399						38
39	Various	2008	142,443						39
40	Lighting	2009	25,289						40
41	Elevator	2009	3,266						41
42	Satellite	2009	2,285						42
43	Oxygen Shed	2009	2,604						43
44	Airconditioning	2009	1,574						44
45	Wallpaper and Painting	2009	9,358						45
46	Courtyard	2009	15,207						46
47	Kitchen - Wall Construction / Design Plans	2009	12,766						47
48	Hot Water Heater	2010	7,190						48
49	Courtyard Doors	2010	9,567						49
50	3 Rooftop A/C Units	2010	71,191						50
51	Resident Room Blinds	2010	694						51
52	Kitchen Project - Wall Construction / Vents / Lights	2010	1,418						52
53	Maintenance Building - Roof / Gutter/ Paint	2010	8,522						53
54	Well Pump - New Pump / Pipe / Wiring	2010	27,659						54
55	Pumphouse - Gutters / Siding / Doors	2010	6,162						55
56	Resident Rooms - Paint and Wall Paper / Base Cove / Stain	2010	19,384						56
57	Dining Rooms / Sitting Rooms - Doors / Paint / Chair Rail	2010	6,147						57
58	Pumphouse - Gutters / Siding / Doors	2010	2,561						58
59	Lighting - Hallways / Offices / Sitting Areas	2011	13,356						59
60	Doors and Door Alarms	2011	20,513						60
61	Maintenance Building - Roof / Gutter/ Paint	2011	14,980						61
62	Well Pump - Line Pipe	2011	2,597						62
63	S/E Med Room - Cabinets / Walls	2011	3,236						63
64	Construction - Main Entrance & Awning, Dining Room Exp.	2012	1,186,682						64
65	Generator Rebuild	2012	22,551						65
66									66
67									67
68									68
69	Financial Statement Depreciation			232,846		232,846		4,196,853	69
70	TOTAL (lines 4 thru 69)		$ 6,428,217	$ 232,846		$ 232,846	$	$ 4,196,853	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 Home # 0001099 Report Period Beginning: 12/01/11 Ending: 11/30/12

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 12B, Carried Forward		$ 6,428,217	$ 232,846		$ 232,846	$	$ 4,196,853	1
2	The following assets were written off in 2012								2
3	and will be adjusted against historical costs								3
4	claimed on this report in future filing periods.								4
5									5
6	Various	1983	(4,778)						6
7	Various	1984	(3,719)						7
8	Various	1985	(5,377)						8
9	Various	1988	(5,322)						9
10	Various	1989	(12,525)						10
11	Various	1991	(3,037)						11
12	Various	1992	(16,291)						12
13	Various	1993	(14,777)						13
14	Various	1994	(5,739)						14
15	Various	1996	(2,495)						15
16	Various	1997	(1,517)						16
17	Various	1998	(3,550)						17
18	Various	1999	(23,138)						18
19	Various	2001	(12,039)						19
20	Various	2003	(22,003)						20
21	Various	2004	(2,709)						21
22	Various	2005	(6,979)						22
23	Various	2007	(5,290)						23
24	Various	2008	(8,562)						24
25	Various	2010	(7,190)						25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,261,180	$ 232,846		$ 232,846	$	$ 4,196,853	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 Home # 0001099 Report Period Beginning: 12/01/11 Ending: 11/30/12

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	$ 2,049,438	$ 33,196	$ 33,196	$	5 - 20	$ 813,084	71
72	Current Year Purchases	23,093	423	423		10	423	72
73	Fully Depreciated Assets							73
74	Disposed Assets	(308,678)						74
75	TOTALS	$ 1,763,853	$ 33,619	$ 33,619	$		$ 813,507	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	Patient Transportation	Pickup / Caravan / Trucks	Various	$ 46,676	$	$	$	10	$ 46,676	76
77	Patient Transportation	Dodge Van	2005	10,575	1,058	1,058		10	8,284	77
78	Patient Transportation	Dodge Caravan	2007	28,000	2,800	2,800		10	16,333	78
79	Patient Transportation	Ford E-350 Shuttle Bus	2008	55,114	5,511	5,511		10	22,964	79
80	TOTALS			$ 140,365	$ 9,369	$ 9,369	$		$ 94,257	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)	$ 8,444,593	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 275,834	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 275,834	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)	$ 5,104,617	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

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/11 Ending: 11/30/12

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								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

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.	/2013	$
13.	/2014	$
14.	/2015	$

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: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* 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

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/11 Ending: 11/30/12

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
   - [X] 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)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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 Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 01	hrs	$ 34,043		$	$		$ 34,043	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			36,898			36,898	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	66,384					66,384	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 prescrpts				39,177		39,177	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Supp. Schedule	39 - 02					6,167		6,167	12
13	Other (specify): Supp. Schedule	39 - 03				5,866			5,866	13
14	TOTAL			$ 100,427		$ 42,764	$ 45,344		$ 188,535	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

Hillcrest Home
Medicaid Cost Report
12/01/11 - 11/30/12

Page 16 Supplemental Schedule

Description	Supplies	Other
Medical Supplies	5,710	
Therapy Supplies	457	
Laboratory / Radiology		5,866
Total	6,167	5,866

STATE OF ILLINOIS

Facility Name & ID Number Hillcrest Home # 0001099 **Report Period Beginning:** 12/01/11 **Ending:** 11/30/12

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/12 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,992,283	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 20,000)	816,682		3
4	Supply Inventory (priced at Cost)	28,657		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	595		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Supplemental Schedule	611		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,838,828	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	279,195		13
14	Buildings, at Historical Cost	6,908,236		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,116,797		16
17	Accumulated Depreciation (book methods)	(5,104,617)		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): Supplemental Schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,199,611	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,038,439	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 131,977	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	209,073		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Supplemental Schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 341,050	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 341,050	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,697,389	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,038,439	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

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Page 17 Supplemental Schedule

Description	Operating	After Consolidation
Line 9 - Other Current Assets		
Accrued Interest	611	
Total	611	-
Line 23 - Other Long Term Assets		
Total	-	-
Line 36 - Other Current Liabilities		
Total	-	-
Line 43 - Other Long Term Liabilities		
Total	-	-

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,693,694	1
2	Restatements (describe):		2
3	**PY Income Adjustments - See Supplemental Schedule**	320,070	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,013,764	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	683,625	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)**	$ 683,625	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)**	$ 5,697,389	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

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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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,098,317	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,098,317	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	137,097	6
7	Oxygen	27,562	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 164,659	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	24	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	40,625	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 40,649	23
	D. Non-Operating Revenue		
24	Contributions	247,852	24
25	Interest and Other Investment Income***	11,794	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 259,646	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Supplemental Schedule	675,221	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 675,221	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,238,492	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,028,039	31
32	Health Care	2,257,670	32
33	General Administration	1,356,558	33
	B. Capital Expense		
34	Ownership	301,659	34
	C. Ancillary Expense		
35	Special Cost Centers	199,108	35
36	Provider Participation Fee	411,833	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,554,867	40
41	**Income before Income Taxes (line 30 minus line 40)****	683,625	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 683,625	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,680,414	44
45	Private Pay - Net Inpatient Revenue	1,918,824	45
46	Medicare - Net Inpatient Revenue	468,984	46
47	Other-(specify) Veterans - Net Inpatient Revenue	30,095	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,098,317	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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.**

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

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Page 19 Supplemental Schedule

Description	Total	Adjustment
Line 28 - Other Revenue		
Rent Income	11,100	No Related Expense
FICA Reimbursement - Henry County	217,295	See Page 6
IMRF Reimburement - Henry County	220,809	See Page 6
Insurance Reimbursement - Henry County	190,981	See Page 6
Transportation Income	11,841	Page 5 Adjustment
Activity Income	4,783	Page 5 Adjustment
Miscellaneous Income	75	Page 5 Adjustment
Concession Income	14,002	Page 5 Adjustment
Meal Income	4,335	Page 5 Adjustment
Total	675,221	

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,720	2,080	$ 69,700	$ 33.51	1
2	Assistant Director of Nursing	1,639	2,080	64,299	30.91	2
3	Registered Nurses	12,775	14,456	298,373	20.64	3
4	Licensed Practical Nurses	19,665	22,366	407,452	18.22	4
5	CNAs & Orderlies	80,845	90,925	1,037,195	11.41	5
6	CNA Trainees					6
7	Licensed Therapist	3,296	3,518	100,427	28.55	7
8	Rehab/Therapy Aides	1,767	2,080	61,760	29.69	8
9	Activity Director					9
10	Activity Assistants	5,029	6,013	66,758	11.10	10
11	Social Service Workers	1,757	2,080	43,343	20.84	11
12	Dietician					12
13	Food Service Supervisor	1,713	2,080	31,999	15.38	13
14	Head Cook	3,580	4,188	47,534	11.35	14
15	Cook Helpers/Assistants	20,338	22,405	224,354	10.01	15
16	Dishwashers					16
17	Maintenance Workers	5,458	6,237	84,786	13.59	17
18	Housekeepers	6,585	7,635	71,945	9.42	18
19	Laundry	7,027	7,967	78,510	9.85	19
20	Administrator	1,792	2,080	72,810	35.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,889	10,602	159,142	15.01	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	901	1,027	11,735	11.43	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	184,776	209,819	$ 2,932,122 *	$ 13.97	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	158	$ 6,968	01 - 03	35
36	Medical Director	16	1,200	09 - 03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	6,983	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	12	780	12 - 03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	282	$ 15,931		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	39	$ 2,246	10 - 03	50
51	Licensed Practical Nurses	741	28,631	10 - 03	51
52	Certified Nurse Assistants/Aides	253	6,257	10 - 03	52
53	TOTAL (lines 50 - 52)	1,033	$ 37,134		53

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

** See instructions.

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mary Bergren	Administrator	0	$ 72,810
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 72,810

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Hesse Martone, PC	Legal	$ 800
Jeremy Brune & Assoc., LLC	Accounting	3,778
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 4,578

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 128,715
Unemployment Compensation Insurance	
FICA Taxes	217,295
Employee Health Insurance	357,503
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	245,878
Other Miscellaneous Benefits	4,146
TOTAL (agree to Schedule V, line 22, col.8)	$ 953,537

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,036
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	1,282
Dues, Subscriptions, and Licenses	4,806
Public Relations and Advertising	3,486
Less: Public Relations Expense	( )
Non-allowable advertising	(3,486)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,124

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,333
Seminar Expense	2,450
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,783

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

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Page 21 Seminar and Travel Schedule

Course Name	Date	Location	Attendee	Job Description	Seminar	Travel
INHAA - Quarterly Conference	06/05/12 - 06/06/12	East Peoria, IL	Bergren	Administrator	95	222
INHAA - Quarterly Conference	03/15/12 - 03/16/12	East Peoria, IL	Bergren	Administrator	95	266
INHAA - Quarterly Conference	08/09/12 - 08/10/12	Bloomington, IL	Bergren	Administrator	95	231
INHAA - Quarterly Conference	08/09/12 - 08/10/12	Bloomington, IL	Kaufman	Accounting Supervisor	95	
INHAA - Annual Conference	10/30/12 - 10/31/12	Springfield, IL	Bergren	Administrator	125	371
Summit Education - Fall Prevenition	03/17/12	On-Line	Diericx	Nursing	179	
Summit Education - Infection Control	04/04/12	On-Line	Schmoll	Nursing	69	
Ramirez Consulting - QIS	11/02/12	Moline, IL	Thompson	Social Services	95	
Creative Forecasting	N/A	N/A	Gradert	Activities	60	
IAPA - Annual Conference	10/24/12 - 10/26/12	Decatur, IL	Grant	Activities	250	193
IAPA - Annual Conference	10/24/12 - 10/26/12	Decatur, IL	Gradert	Activities	250	
Ramirez Consulting - QIS	11/02/12	Moline, IL	Agnel	Activities	95	
Educational DVDs and Booklets	N/A	N/A	N/A	N/A	947	
Various - Other						51
Total					2,450	1,333

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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		$		$	$	$	$	$	$	$	$	$

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **CNHA - $505 and INHAA - $100**

(3) Did the nursing home make political contributions or payments to a politica
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. $ **51,784** Line **10 - 02**

(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 fo
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
during this cost report period. $ **411,833**
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.

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(13) Have costs for all supplies and services which are of the type that can be billed tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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? **Yes** Indicate the amount. $ **18,337**

(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 fo
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? **Yes**
e. Are all vehicles stored at the nursing home during the night and all othe
times when not in use? **Yes**
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? **Yes**
Firm Name: **Carpenter, Mitchell, Goddard & Co., LLC**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of service
performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees