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: 0050690

Facility Name: Hillcrest Nursing & Rehab Center

Address: 777 Draper Avenue (Number) Joliet (City) 60432 (Zip Code)

County: Will

Telephone Number: (815) 727 - 4794 Fax # (815) 727 - 1026

HFS ID Number:

Date of Initial License for Current Owners: 12/16/09

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Edward N. Slack, CPA Telephone Number: (847) 628 - 8796
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 01/01/12 to 12/31/12 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)

(Title)

Paid Preparer

(Signed) (Date)

(Print Name and Title) Edward N. Slack, CPA, Partner, Health and Human Services

(Firm Name & Address) Plante & Moran, PLLC, 2155 Point Boulevard, Suite 200 Elgin, Illinois 60123

(Telephone) (847) 628 - 8796 Fax # (248) 327 - 8417

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

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	84	Skilled (SNF)	84	30,744	1
2		Skilled Pediatric (SNF/PED)			2
3	84	Intermediate (ICF)	84	30,744	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	168	TOTALS	168	61,488	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			486	486	8
9	SNF/PED					9
10	ICF	11,798	6,209		18,007	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,798	6,209	486	18,493	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 30.08%

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 486

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/12 Fiscal Year: 12/31/12

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	155,328	28,105	10,933	194,366		194,366	(398)	193,968			1
2	Food Purchase		134,130		134,130		134,130	184	134,314			2
3	Housekeeping	145,889	34,174		180,063		180,063	184	180,247			3
4	Laundry	37,863	14,425		52,288		52,288		52,288			4
5	Heat and Other Utilities			101,949	101,949		101,949	(30,112)	71,837			5
6	Maintenance	77,378		132,086	209,464		209,464	2,760	212,224			6
7	Other (specify):* See Supplemental	264,974		820	265,794		265,794	1,012	266,806			7
8	TOTAL General Services	681,432	210,834	245,788	1,138,054		1,138,054	(26,370)	1,111,684			8
	B. Health Care and Programs											
9	Medical Director			24,165	24,165		24,165	(9,000)	15,165			9
10	Nursing and Medical Records	1,088,172	18,416	71,039	1,177,627		1,177,627		1,177,627			10
10a	Therapy	79,946			79,946		79,946		79,946			10a
11	Activities	82,277	33,747		116,024		116,024		116,024			11
12	Social Services	198,829	3,386	943	203,158		203,158		203,158			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* See Supplemental											15
16	TOTAL Health Care and Programs	1,449,224	55,549	96,147	1,600,920		1,600,920	(9,000)	1,591,920			16
	C. General Administration											
17	Administrative	156,618			156,618		156,618	6,471	163,089			17
18	Directors Fees											18
19	Professional Services			309,803	309,803		309,803	(148,180)	161,623			19
20	Dues, Fees, Subscriptions & Promotions			15,717	15,717		15,717	(5,535)	10,182			20
21	Clerical & General Office Expenses	92,507	14,439	202,004	308,950		308,950	(136,795)	172,155			21
22	Employee Benefits & Payroll Taxes			452,987	452,987		452,987	(4,045)	448,942			22
23	Inservice Training & Education			246	246		246		246			23
24	Travel and Seminar			1,822	1,822		1,822	86	1,908			24
25	Other Admin. Staff Transportation			12,723	12,723		12,723	319	13,042			25
26	Insurance-Prop.Liab.Malpractice			142,465	142,465		142,465	376	142,841			26
27	Other (specify):* See Supplemental							9,761	9,761			27
28	TOTAL General Administration	249,125	14,439	1,137,767	1,401,331		1,401,331	(277,542)	1,123,789			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,379,781	280,822	1,479,702	4,140,305		4,140,305	(312,912)	3,827,393			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.

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

Page 3 Supplemental Schedule

Description	Salaries	Supplies	Other
Line 7 Detailed			
Security	264,974		820
Allocation - Extended Care Consulting: Emp. Ben.			1,012
Total	264,974	-	1,832
Line 15 Detailed			
Total	-	-	-
Line 27 Detailed			
Allocation - Extended Care Consulting: Emp. Ben.			9,761
Total	-	-	9,761

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

Page 3 Supplemental Schedule - Other Admin. Staff Transportation

Payee	Amount	Allowable
Alice Apara-Olujimi	1,871	1,871
Amy Sparks	285	285
Care Consultants of Illinois	4,011	4,011
Crystal Eichhorst	1,506	1,506
Jakob Bakst	111	111
Kevin Meals	500	500
Mike Scalise	2,313	2,313
Scott Turner	153	153
Sheryl Schreiber	93	93
Tyson Motors	357	357
John Coglianese	947	947
Other	576	576
Alloc. - Extended Care Consulting	319	319
	13,042	13,042

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

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	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			9,483	9,483		9,483	214,321	223,804			30
31	Amortization of Pre-Op. & Org.							8,744	8,744			31
32	Interest			25,769	25,769		25,769	403,348	429,117			32
33	Real Estate Taxes							97,176	97,176			33
34	Rent-Facility & Grounds			735,687	735,687		735,687	(731,617)	4,070			34
35	Rent-Equipment & Vehicles			35,343	35,343		35,343	412	35,755			35
36	Other (specify):* See Supplement											36
37	TOTAL Ownership			806,282	806,282		806,282	(7,616)	798,666			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		71,904	123,628	195,532		195,532	(6,549)	188,983			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			169,432	169,432		169,432		169,432			42
43	Other (specify):* See Supplement											43
44	TOTAL Special Cost Centers		71,904	293,060	364,964		364,964	(6,549)	358,415			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,379,781	352,726	2,579,044	5,311,551		5,311,551	(327,077)	4,984,474			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

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

Page 4 Supplemental Schedule

Description	Salaries	Supplies	Other
Line 36 Detailed			
Total	-	-	-
Line 43 Detailed			
Non-Allowable			
Total	-	-	-

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

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
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	(5,519)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(403)	01		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	(101,673)	21		18
19	Entertainment				19
20	Contributions	(768)	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	(48,000)	21		24
25	Fund Raising, Advertising and Promotional	(6,163)	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 See Supplemental	(91,828)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (254,354)		$	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)	(72,723)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (72,723)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (327,077)		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 Nursing & Rehab Center

ID# 0050690

Report Period Beginning: 01/01/12

Ending: 12/31/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Other Expenses	$ (14,529)	21	1
2	Collection Expense	(408)	21	2
3	Theft Loss	(353)	21	3
4	Bank Charges	(14,027)	21	4
5	PP Adjustment - Psych Bills	(9,000)	09	5
6	PP Adjustment - Medical Supplies	(5,209)	39	6
7	PP Adjustment - Laboratory	(126)	39	7
8	Utility Deposits	(30,378)	05	8
9	Building Rental - TAG Property	(8,715)	34	9
10	Non-Allowable Legal	(10,590)	19	10
11	Capitalized Assets - Cost < $2,500	1,706	06	11
12				12
13				13
14				14
15	Hillcrest Realty, LLC			15
16	Bank Fees	(199)	21	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**	(91,828)		49

STATE OF ILLINOIS

Summary A

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

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	(403)	0	96	0	0	(91)	0	0	0	0	0	(398)	1
2	Food Purchase	0	0	184	0	0	0	0	0	0	0	0	184	2
3	Housekeeping	0	0	184	0	0	0	0	0	0	0	0	184	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(30,378)	0	266	0	0	0	0	0	0	0	0	(30,112)	5
6	Maintenance	1,706	0	1,054	0	0	0	0	0	0	0	0	2,760	6
7	Other (specify):*	0	0	0	1,012	0	0	0	0	0	0	0	1,012	7
8	**TOTAL General Services**	(29,075)	0	1,784	1,012	0	(91)	0	0	0	0	0	(26,370)	8
	B. Health Care and Programs													
9	Medical Director	(9,000)	0	0	0	0	0	0	0	0	0	0	(9,000)	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(9,000)	0	0	0	0	0	0	0	0	0	0	(9,000)	16
	C. General Administration													
17	Administrative	0	0	1,139	5,332	0	0	0	0	0	0	0	6,471	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(10,590)	0	(137,590)	0	0	0	0	0	0	0	0	(148,180)	19
20	Fees, Subscriptions & Promotions	(6,931)	0	1,396	0	0	0	0	0	0	0	0	(5,535)	20
21	Clerical & General Office Expenses	(179,189)	199	4,765	37,430	0	0	0	0	0	0	0	(136,795)	21
22	Employee Benefits & Payroll Taxes	0	0	0	(4,045)	0	0	0	0	0	0	0	(4,045)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	86	0	0	0	0	0	0	0	0	86	24
25	Other Admin. Staff Transportation	0	0	319	0	0	0	0	0	0	0	0	319	25
26	Insurance-Prop.Liab.Malpractice	0	0	376	0	0	0	0	0	0	0	0	376	26
27	Other (specify):*	0	0	0	9,761	0	0	0	0	0	0	0	9,761	27
28	**TOTAL General Administration**	(196,710)	199	(129,509)	48,478	0	0	0	0	0	0	0	(277,542)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(234,785)	199	(127,725)	49,490	0	(91)	0	0	0	0	0	(312,912)	29

STATE OF ILLINOIS

Summary B

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

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	0	211,645	2,676	0	0	0	0	0	0	0	0	214,321	30
31	Amortization of Pre-Op. & Org.	0	8,744	0	0	0	0	0	0	0	0	0	8,744	31
32	Interest	(5,519)	407,203	1,664	0	0	0	0	0	0	0	0	403,348	32
33	Real Estate Taxes	0	96,332	844	0	0	0	0	0	0	0	0	97,176	33
34	Rent-Facility & Grounds	(8,715)	(722,902)	0	0	0	0	0	0	0	0	0	(731,617)	34
35	Rent-Equipment & Vehicles	0	0	412	0	0	0	0	0	0	0	0	412	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(14,234)	1,022	5,596	0	0	0	0	0	0	0	0	(7,616)	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	(5,335)	0	0	0	0	(45)	(144)	0	(1,025)	0	0	(6,549)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(5,335)	0	0	0	0	(45)	(144)	0	(1,025)	0	0	(6,549)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(254,354)	1,221	(122,129)	49,490	0	(136)	(144)	0	(1,025)	0	0	(327,077)	45

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

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
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. [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	34	Rent	$ 722,902	Hillcrest Realty, LLC	100.00%	$	$ (722,902)	1
2	V	21	Bank Service Fees		Hillcrest Realty, LLC	100.00%	199	199	2
3	V	21	Filing Fees		Hillcrest Realty, LLC	100.00%			3
4	V	30	Depreciation		Hillcrest Realty, LLC	100.00%	211,645	211,645	4
5	V	31	Amortization		Hillcrest Realty, LLC	100.00%	8,744	8,744	5
6	V	32	Interest		Hillcrest Realty, LLC	100.00%	407,203	407,203	6
7	V	33	Real Estate Taxes		Hillcrest Realty, LLC	100.00%	96,332	96,332	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 722,902			$ 724,123	$ * 1,221	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 # 0050690 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	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	2201 Main	Evanston, IL	Bldg. Company	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				10
11			Snow Vally Nursing and Rehab	Lisle, IL	Hillcrest			11
12			South Suburban Rehabilitation Center	Chicago, IL	Realty, LLC	Joliet, IL	Bldg. Company	12
13			Tri-State Nursing and Rehab	Lansing, IL				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 Nursing Center	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

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

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 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)	
15	V	01	Dietary	$	Extended Care Consulting, LLC	100.00%	$ 96	$ 96	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	184	184	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	184	184	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	266	266	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	1,054	1,054	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	1,139	1,139	20
21	V	19	Professional Fees	139,200	Extended Care Consulting, LLC	100.00%	1,610	(137,590)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,396	1,396	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	4,765	4,765	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	86	86	24
25	V	25	Other Staff Admin. Transport.		Extended Care Consulting, LLC	100.00%	319	319	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	376	376	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	2,676	2,676	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	1,664	1,664	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	844	844	29
30	V	35	Rent - Equipment and Auto		Extended Care Consulting, LLC	100.00%	412	412	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			$ 139,200			$ 17,071	$ * (122,129)	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 # 0050690 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 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)	
15	V	06	Maintenance	$ 2,463	Extended Care Consulting, LLC	100.00%	$ 2,463	$	15
16	V	06	Maintenance	101,706	Extended Care Consulting, LLC	100.00%	101,706		16
17	V	07	Employee Benefits	453	Extended Care Consulting, LLC	100.00%	453		17
18	V	07	Employee Benefits	15,887	Extended Care Consulting, LLC	100.00%	16,899	1,012	18
19	V	10	Nursing		Extended Care Consulting, LLC	100.00%			19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	5,332	5,332	20
21	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	37,430	37,430	21
22	V	21	Office and Clerical	11,459	Extended Care Consulting, LLC	100.00%	11,459		22
23	V	27	Employee Benefits		Extended Care Consulting, LLC	100.00%	7,857	7,857	23
24	V	27	Employee Benefits		Extended Care Consulting, LLC	100.00%	1,904	1,904	24
25	V	22	Employee Benefits	4,045	Extended Care Consulting, LLC	100.00%		(4,045)	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			$ 136,013			$ 185,503	$ * 49,490	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 # 0050690 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 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)	
15	V	22	Health Insurance	$ 46,164	CCS VEBA	100.00%	$ 46,164	$	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			$ 46,164			$ 46,164	$ *	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 # 0050690 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 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)	
15	V	1	Dietary	$ 324	Care Centers Health Systems, Inc.	100.00%	$ 233	$ (91)	15
16	V	10	Nursing		Care Centers Health Systems, Inc.	100.00%			16
17	V	39	Ancillary	161	Care Centers Health Systems, Inc.	100.00%	116	(45)	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			$ 485			$ 349	$ * (136)	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 # 0050690 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 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)	
15	V	39	Ancillary	$ 82,785	Tricare Rehab	100.00%	$ 82,641	$ (144)	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			$ 82,785			$ 82,641	$ * (144)	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 # 0050690 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 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)	
15	V	39	Ancillary	$	Reliable Medical of the Midwest, LLC	100.00%	$	$	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			$			$ 0	$ *	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 # 0050690 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 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)	
15	V	39	Ancillary	$ 1,800	Vent Lease, LLC	100.00%	$ 775	$ (1,025)	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			$ 775	$ * (1,025)	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 # 0050690 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	Adam Vales	Relative	Clerical	0	See Attached	0.31	0.77%	Alloc. Sal	$ 560	21 - 07	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	$ 560		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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 Nursing & Rehab Center # 0050690 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 [X] 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	01	Dietary	Patient Days	1,364,178	31	$ 7,101	$	18,493	$ 96	1
2	02	Food	Patient Days	1,364,178	31	13,586		18,493	184	2
3	03	Housekeeping	Patient Days	1,364,178	31	13,573		18,493	184	3
4	05	Utilities	Patient Days	1,364,178	31	19,636		18,493	266	4
5	06	Maintenance	Patient Days	1,364,178	31	77,756		18,493	1,054	5
6	17	Administrative	Patient Days	1,364,178	31	84,000		18,493	1,139	6
7	19	Professional Fees	Patient Days	1,364,178	31	118,750		18,493	1,610	7
8	20	Dues and Subscriptions	Patient Days	1,364,178	31	102,984		18,493	1,396	8
9	21	Office and Clerical	Patient Days	1,364,178	31	351,528		18,493	4,765	9
10	24	Seminar and Travel	Patient Days	1,364,178	31	6,315		18,493	86	10
11	25	Other Staff Admin. Transpor.	Patient Days	1,364,178	31	23,506		18,493	319	11
12	26	Insurance	Patient Days	1,364,178	31	27,741		18,493	376	12
13	30	Depreciation	Patient Days	1,364,178	31	197,424		18,493	2,676	13
14	32	Interest	Patient Days	1,364,178	31	122,765		18,493	1,664	14
15	33	Real Estate Taxes	Patient Days	1,364,178	31	62,275		18,493	844	15
16	35	Rent - Equipment and Auto	Patient Days	1,364,178	31	30,363		18,493	412	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,259,303	$		$ 17,071	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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 [X] 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	1,364,178	31	$ 181,713	$ 181,713	18,493	$ 2,463	1
2	06	Maintenance	Direct Allocation	1	1	101,706	101,706	1	101,706	2
3	07	Employee Benefits	Patient Days	1,364,178	31	33,386		18,493	453	3
4	07	Employee Benefits	Direct Allocation	1	1	16,899		1	16,899	4
5	17	Administrative	Patient Days	1,364,178	31	393,362	393,362	18,493	5,332	5
6	21	Office and Clerical	Patient Days	1,364,178	31	2,761,089	2,761,089	18,493	37,430	6
7	21	Office and Clerical	Direct Allocation	1	1	11,459	11,459	1	11,459	7
8	27	Employee Benefits	Patient Days	1,364,178	31	579,570		18,493	7,857	8
9	27	Employee Benefits	Direct Allocation	1	1	1,904		1	1,904	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					$ 4,081,088	$ 3,449,329		$ 185,503	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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 [X] 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	$ 46,164	$	1	$ 46,164	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					$ 46,164	$		$ 46,164	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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 [X] 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 Avenue #246
City / State / Zip Code: Des Plaines, Illinois 60018
Phone Number: ((224) 612 - 5662
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	Dietary	Profit Margin %	167,706	21	$ 120,751	$	324	$ 233	1
2	10	Nursing	Profit Margin %	4,037	21	2,907				2
3	39	Ancillary	Profit Margin %	177,899	21	128,090		161	116	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					$ 251,748	$		$ 349	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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 [X] NO [ ]

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

Name of Related Organization: Tricare Rehab
Street Address: 150 Fencl 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	Ancillary	Profit Margin %	10,092,326	17	$ 10,074,726	$	82,785	$ 82,641	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					$ 10,074,726	$		$ 82,641	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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 [X] NO [ ]

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

Name of Related Organization: Reliable Medical of the Midwest, LLC
Street Address: 200 Howard Avenue, Suite 246
City / State / Zip Code: Des Plaines, Illinois 60018
Phone Number: (847) 566 - 0800
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	39	Ancillary	Profit Margin %	310,589	15	$ 307,825	$		$	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					$ 307,825	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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 ☐

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	Profit Margin %	185,250	19	$ 79,751	$	1,800	$ 775	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					$ 79,751	$		$ 775	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	Lake Forest		X	Mortgage			$	$ 5,069,434			$ 407,203	1
2												2
3												3
4												4
5												5
	Working Capital											
6	HFG	X		Line of Credit				1,350,772			13,241	6
7	Citicard		X	Credit Card							12,528	7
8												8
9	TOTAL Facility Related						$	$ 6,420,206			$ 432,972	9
	B. Non-Facility Related*											
10												10
11	Alloc. - Extended Care	X									1,664	11
12												12
13	Interest Income		X								(5,519)	13
14	TOTAL Non-Facility Related						$	$			$ (3,855)	14
15	TOTALS (line 9+line14)						$	$ 6,420,206			$ 429,117	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 Nursing & Rehab Center # 0050690 Report Period Beginning: 01/01/12 Ending: 12/31/12

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.**	$ 85,473	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.)		$ 89,530	2
3. Under or (over) accrual (line 2 minus line 1).		$ 4,057	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 93,119	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.		$ 97,176	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	71,559	8
	2008	72,380	9
	2009	75,048	10
	2010	81,402	11
	2011	88,684	12

	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

2012 Real Estate Tax Accrual = $88,684 * 1.05 = $93,119

Extended Care Consulting, LLC (Allocation) - $844

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 Nursing & Rehab Center COUNTY Will

FACILITY IDPH LICENSE NUMBER 0050690

CONTACT PERSON REGARDING THIS REPORT Edward N. Slack

TELEPHONE (847) 628 - 8796 FAX #: (248) 327 - 8417

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.	30-07-11-101-003-0000	Long Term Care Facility	$ 88,683.80	$ 88,683.80
2.			$	$
3.			$	$
4.	Allocation	Extended Care Consulting, LLC	$ 127,119.67	$ 670.73
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 215,803.47	$ 89,354.53

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 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 Nursing & Rehab Center # 0050690 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			$ 336,000	1
2	Ext. Care Consult.			4,327	2
3	TOTALS			$ 340,327	3

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	168			1976	$ 5,288,000	$ 192,291	27.5	$ 192,291	$	$ 1,046,329	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						30
31	Sidewalk Renovations			2010	4,750						31
32	Security Systems- Replace VDR and 7 Cameras			2010	3,600						32
33	Replace Water Heater			2010	2,585						33
34	Replace Main Lighting and Heating Circuit Breakers			2010	14,400						34
35	Replace Kitchen Heating and Cooling Unit			2010	7,100						35
36	Electrical Work for Four Rooms on 2nd Floor and Main Dining			2010	4,150						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 Nursing & Rehab Center # 0050690 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	Shingle, Drain and Downspout Replacement	2010	$ 10,380	$		$	$	$	37
38	Duro Last Drains	2010	3,400						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						43
44	Roof Repair	2011	7,650						44
45	Office Area Ductwork	2011	3,274						45
46	1st Flr - Dining Room / Resident Rooms - Plaster, Prime, Paint	2012	17,430						46
47	3rd Flr - Resident Rooms / Hallways - Plaster, Primate, Paint, Cub	2012	169,706						47
48	2nd Flr - Resident Rooms / Hallways - Plaster, Prime, Paint, Wallp	2012	181,630						48
49	Water Heater	2012	2,568						49
50	3rd Flr - Resident Rooms - Overbed Light Fixtures	2012	10,184						50
51	3rd Flr - Entrance Keypads, Sirens, and Door Monitor	2012	3,372						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	Financial Statement Depreciation			6,651		6,651		11,411	69
70	TOTAL (lines 4 thru 69)		$ 7,093,731	$ 198,942		$ 198,942	$	$ 1,057,740	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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 12A, Carried Forward		$ 7,093,731	$ 198,942		$ 198,942	$	$ 1,057,740	1
2									2
3	Related Party Allocations - See Supplemental Schedules								3
4									4
5	Allocations - Extended Care Consulting	2007	62	3	20	3		19	5
6	Allocations - Extended Care Consulting	2009	37	2	20	2		7	6
7	Allocations - Extended Care Consulting	2010	366	18	20	18		55	7
8	Allocations - Extended Care Consulting	2011	132	7	20	7		13	8
9	Allocations - Extended Care Consulting	2012	43	2	20	2		2	9
10									10
11	Allocations - Extended Care Consulting / 2201 Main LLC	2002	5,962	153	39	153		1,573	11
12	Allocations - Extended Care Consulting / 2201 Main LLC	2002	4,925	450	10	450		4,055	12
13	Allocations - Extended Care Consulting / 2201 Main LLC	2003	5,804	530	10	530		4,779	13
14	Allocations - Extended Care Consulting / 2201 Main LLC	2005	288	31	10	31		196	14
15	Allocations - Extended Care Consulting / 2201 Main LLC	2009	52	3	10	3		10	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,111,402	$ 200,141		$ 200,141	$	$ 1,068,449	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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	$ 15,560	$ 1,556	$ 1,556	$	5 - 7	$ 7,602	71
72	Current Year Purchases	12,760	1,276	1,276		5	1,276	72
73	Fully Depreciated Assets							73
74	See Supplemental	391,998	20,411	20,411			374,922	74
75	TOTALS	$ 420,318	$ 23,243	$ 23,243	$		$ 383,800	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				$	$	$	$		$	76
77	Alloc. - Extended Care			2,101	420	420		5	2,101	77
78										78
79										79
80	TOTALS			$ 2,101	$ 420	$ 420	$		$ 2,101	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)	$ 7,874,148	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 223,804	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 223,804	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)	$ 1,454,350	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.

SEE ACCOUNTANTS' COMPILATION REPORT

** This must agree with Schedule V line 30, column 8.

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

Page 13 Supplemental Schedule

Description	Cost	Depreciation	Accumulated Depreciation
Related Party 1 - Hillcrest Realty, LLC			
Prior	336,000	19,354	320,517
Current			
Total	336,000	19,354	320,517
Related Party 2 - Extended Care Consulting			
Prior	39,826	140	38,960
Current			
Total	39,826	140	38,960
Related Party 3 - Extended Care Consulting / 2201 Mail LLC			
Prior	1,651	165	1,632
Current			
Total	1,651	165	1,632
Related Party 4 - Extended Care Consulting - Matrix Software			
Prior	14,521	752	13,813
Current			
Total	14,521	752	13,813
Total	**391,998**	**20,411**	**374,922**

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

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. [X] 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.				4,070			6
7	TOTAL				$ 4,070 **			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 [X] NO
16. Rental Amount for movable equipment: $ 22,242 Description: 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	Various	$	$ 5,881	17
18	Facility	Acura		7,632	18
19					19
20					20
21	TOTAL		$	$ 13,513	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

Hillcrest Nursing & Rehab Center
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Page 14 Supplemental Schedule - Building and Fixed Equipment

Vendor	Description	Amount
TAG Properties	Building Rental	8,715
Off Site Storage Rental		4,070
Non-Allowable		(8,715)
Total		4,070

Page 14 Supplemental Schedule - Equipment Rental

Vendor	Description	Amount
Advacare Systems		660
Extended Care Consultants		63
GE Capital		9,075
Global Medical		1,429
Hasler		355
Hughes Enterprises		10,150
Meikem		71
RCS Superior Respiratory		28
Alloc. - Extended Care Consulting		412
Total		22,242

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

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

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

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 - 03	hrs	$		$ 42,454	$		$ 42,454	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			1,872			1,872	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			38,683			38,683	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				36,024		36,024	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					35,880		35,880	12
13	Other (specify): See Supplemental	39 - 03				40,619			40,619	13
14	TOTAL			$		$ 123,628	$ 71,904		$ 195,532	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 Nursing & Rehab Center
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Page 16 Supplemental Schedule

Description	Supplies	Other
Ambulance		367
Feeding Tube and Supplements		
Food Pump		
Hospital Tests		
Laboratory		20,480
Low Pressure Mattresses	3,038	
Medical Supplies	16,237	
Other Services		6,505
Oxygen	11,231	
Radiology		11,467
Therapy and Rehab Supplies	4,884	
Wheelchairs and Walkers	249	
Medical Equipment		
Prosthetics and Orthotics	241	
Ventilation Equipment and Supplies		1,800
Total	35,880	40,619

STATE OF ILLINOIS

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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/12 (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	$	$ 464,475	1
2	Cash-Patient Deposits	36,899	36,899	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 344,952)	590,211	590,211	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	42,327	42,327	6
7	Other Prepaid Expenses	44,729	44,729	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental		36,030	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 714,166	$ 1,214,671	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	439,533	439,533	15
16	Equipment, at Historical Cost	62,481	398,481	16
17	Accumulated Depreciation (book methods)	(20,289)	(1,406,147)	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		10,569	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 481,725	$ 5,066,436	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,195,891	$ 6,281,107	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 790,516	$ 790,516	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,739	4,739	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	66,453	66,453	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,454	3,454	31
32	Accrued Real Estate Taxes(Sch.IX-B)		93,119	32
33	Accrued Interest Payable		16,110	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental	665,409	987,445	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,530,571	$ 1,961,836	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,350,772	6,420,206	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,350,772	$ 6,420,206	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,881,343	$ 8,382,042	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,685,452)	$ (2,100,935)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,195,891	$ 6,281,107	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Hillcrest Nursing & Rehab Center
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Page 17 Supplemental Schedule

Description	Operating	After Consolidation
Line 9 - Other Current Assets		
Real Estate Tax Escrow		36,030
Total	-	36,030
Line 23 - Other Long Term Assets		
Financing Costs (Net of Amortization)		10,569
Total	-	10,569
Line 36 - Other Current Liabilities		
Due to Related Parties	665,409	987,445
Total	665,409	987,445
Line 43 - Other Long Term Liabilities		
Total	-	-

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

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,412,869	1
2	Restatements (describe):		2
3	**Rounding Adjustments**	(3)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,412,866	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(3,098,318)	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)**	$ (3,098,318)	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)**	$ (1,685,452)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	$ 1,989,557	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,989,557	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	62,594	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 62,594	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,519	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,519	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	155,563	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 155,563	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,213,233	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,138,054	31
32	Health Care	1,600,920	32
33	General Administration	1,401,331	33
	B. Capital Expense		
34	Ownership	806,282	34
	C. Ancillary Expense		
35	Special Cost Centers	195,532	35
36	Provider Participation Fee	169,432	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,311,551	40
41	**Income before Income Taxes (line 30 minus line 40)****	(3,098,318)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (3,098,318)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,516,871	44
45	Private Pay - Net Inpatient Revenue	258,286	45
46	Medicare - Net Inpatient Revenue	198,305	46
47	Other-(specify) Hospice - Net Patient Service Revenue	16,095	47
48	Other-(specify) Insurance - Net Patient Service Revenue		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 1,989,557	49

* 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.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Hillcrest Nursing & Rehab Center
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Page 19 Supplemental Schedule

Description	Total	Adjustment
Line 28 - Other Revenue		
PP Income and Expense Adjustments	121,464	14,335
Other Income	33,645	30,378
Vending Commissions	454	-
Total	155,563	44,713

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

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	1,376	1,457	$ 58,469	$ 40.13	1
2	Assistant Director of Nursing	1,551	1,673	58,126	34.74	2
3	Registered Nurses	6,149	6,545	193,384	29.55	3
4	Licensed Practical Nurses	14,146	15,012	365,572	24.35	4
5	CNAs & Orderlies	33,184	36,651	387,874	10.58	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,849	5,598	79,946	14.28	8
9	Activity Director	1,828	2,126	35,757	16.82	9
10	Activity Assistants	4,966	5,310	46,520	8.76	10
11	Social Service Workers	10,302	10,804	198,829	18.40	11
12	Dietician					12
13	Food Service Supervisor	1,886	2,108	44,848	21.28	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,109	4,474	43,748	9.78	15
16	Dishwashers	6,914	7,613	66,732	8.77	16
17	Maintenance Workers	4,715	5,179	77,378	14.94	17
18	Housekeepers	13,873	15,406	145,889	9.47	18
19	Laundry	3,246	3,715	37,863	10.19	19
20	Administrator	1,890	2,178	97,297	44.67	20
21	Assistant Administrator	545	586	15,637	26.68	21
22	Other Administrative	640	640	43,684	68.26	22
23	Office Manager					23
24	Clerical	5,196	5,712	92,507	16.20	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,642	1,768	24,747	14.00	31
32	Other Health Care(specify)					32
33	Other(specify) Supplemental	28,618	30,552	264,974	8.67	33
34	TOTAL (lines 1 - 33)	151,625	165,107	$ 2,379,781 *	$ 14.41	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

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		$ 10,933	01 - 03	35
36	Medical Director		24,165	09 - 03	36
37	Medical Records Consultant				37
38	Nurse Consultant		66,009	10 - 03	38
39	Pharmacist Consultant		4,705	10 - 03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant		325	10 - 03	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		943	12 - 03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 107,080		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

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Page 20 Supplemental Schedule

Description	Hours Worked	Hours Paid	Salary
Other Salaries			
Security	28,618	30,552	264,974
Total	28,618	30,552	264,974

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Amy Sparks	Administrator	0	$ 33,259
Alice Apara-Olujimi	Administrator	0	64,038
Kevin Meals	Asst. Admin.	0	15,637
John Coglianses	Administration	0	43,684
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 156,618

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
Extended Care Consulting	Home Office	$ 139,200
Krupnic, Bokar & Kagda	Accounting	3,600
Plante & Moran, PLLC	Accounting	20,900
Personnel Planners	Unemployment Consultant	3,194
Laura Feliciano	Admin. Consultant	2,000
AT&T	Computer Maintenance	47
Care Consultants of Illinois	Computer Maintenance	12,040
Comcast Cable	Computer Maintenance	941
OmniCare of Northern Illinois	Computer Maintenance	660
On-Line Communications, Inc.	Computer Maintenance	458
American Data	Data Processing	4,780
See Supplemental Schedule		121,983
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 309,803

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 68,968
Unemployment Compensation Insurance	99,402
FICA Taxes	179,830
Employee Health Insurance	42,984
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	49,167
Other Employee Welfare	7,891
Holiday Expense	700
TOTAL (agree to Schedule V, line 22, col.8)	$ 448,942

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	$ 1,990
Advertising: Employee Recruitment	25
Health Care Worker Background Check	1,187
(Indicate # of checks performed)	
Patient Background Checks	
Dues and Subscriptions	45
Licenses and Fees	5,539
Advertising and Promotion	6,163
Alloc. - Extended Care Consulting	1,396
Less: Public Relations Expense	( )
Non-allowable advertising	(6,163)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,182

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,822
Alloc. - Extended Care Consulting	86
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,908

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

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Page 21 Supplemental Schedule - Other Professional Fees

Vendor	Type	Amount
MDI	Data Processing	14,551
Paycor	Data Processing	7,751
Care Consultants of Illinois	Data Processing	175
E-Health Data Solutions	Data Processing	4,946
Extended Care Consulting	Data Processing	5,367
MediFax-EDI, LLC	Data Processing	551
National DataCare Corporation	Data Processing	1,989
Nebo Systems, Inc.	Data Processing	57
Pro Payroll Solutions	Data Processing	5,089
Other	Data Processing	549
Blymas, Inc.	Other Professional	3,952
Extended Care Consulting	Other Professional	2,413
HFG	Other Professional	17,598
Michigan Peer Review	Other Professional	4,065
Other	Other Professional	125
Burke, Warren MacKay	Legal	4,042
Chuhak & Tecson, P.C.	Legal	713
Extended Care Consulting	Legal	785
Hall, Prangle & Schoonve	Legal	9,927
Law Offices of Michael Z Margolis	Legal	70
Leslie Cox	Legal	3,500
Meyer Magence	Legal	9,743
Neal, Gerber & Eisenberg	Legal	22,353
Wiliams, Montgomery & John	Legal	1,672
Total		121,983

Page 21 Supplemental Schedule - Legal Schedule

Vendor	Date	Amount	Allowable
Burke, Warren, MacKay	01/31/12	941	
Burke, Warren, MacKay	02/29/12	352	
Burke, Warren, MacKay	03/30/12	107	
Burke, Warren, MacKay	04/30/12	253	
Burke, Warren, MacKay	05/31/12	36	
Burke, Warren, MacKay	07/31/12	40	
Burke, Warren, MacKay	08/31/12	280	
Burke, Warren, MacKay	09/30/12	838	
Burke, Warren, MacKay	10/30/12	150	
Burke, Warren, MacKay	11/23/12	585	
Burke, Warren, MacKay	12/20/12	462	
Chuhak & Tecson, P.C.	01/31/12	21	
Chuhak & Tecson, P.C.	01/31/12	180	
Chuhak & Tecson, P.C.	01/31/12	21	
Chuhak & Tecson, P.C.	01/31/01	148	
Chuhak & Tecson, P.C.	07/31/12	259	
Chuhak & Tecson, P.C.	09/24/12	63	
Chuhak & Tecson, P.C.	09/24/12	5	
Chuhak & Tecson, P.C.	09/30/12	42	
Chuhak & Tecson, P.C.	01/31/12	(27)	
Hall, Prangle & Schoonve	11/30/12	4,062	4,062
Hall, Prangle & Schoonve	09/30/12	2,426	2,426
Hall, Prangle & Schoonve	10/30/12	948	948
Hall, Prangle & Schoonve	11/30/12	988	988
Hall, Prangle & Schoonve	12/31/12	840	840
Hall, Prangle & Schoonve	12/31/12	664	664
Law Offices of Michael Z Margolis	06/12/12	70	
Leslie Cox	07/19/12	3,500	3,500
Meyer Magence	01/31/12	6,436	6,436
Meyer Magence	01/31/12	3,307	
Neal, Gerber & Eisenberger	09/30/12	5,814	5,814
Neal, Gerber & Eisenberger	09/30/12	3,415	3,415
Neal, Gerber & Eisenberger	09/30/12	5,593	5,593
Neal, Gerber & Eisenberger	09/30/12	2,863	2,863
Neal, Gerber & Eisenberger	09/30/12	2,813	2,813
Neal, Gerber & Eisenberger	09/30/12	630	630
Neal, Gerber & Eisenberger	09/30/12	1,223	1,223
Williams, Montgomery & John	01/31/12	1,367	
Williams, Montgomery & John	01/31/12	291	
Williams, Montgomery & John	02/22/12	14	
Williams, Montgomery & John	09/30/12	256	
Williams, Montgomery & John	11/28/12	19	
Williams, Montgomery & John	12/20/12	469	
Williams, Montgomery & John	04/30/12	42	
Total		52,805	42,215
Non-Allowable			10,590

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

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

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

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **6,986** Line **Ln 10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES 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 Department during this cost report period. $ **169,432**
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.

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? **N/A**
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