FOR BHF USE

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2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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

I. IDPH License ID Number: 0001099

Facility Name: Hillcrest Home

Address: 14688 IL HWY 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 12/01/12 to 11/30/13 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) Lorna Brown
(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, Illinois 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: 12/01/12 Ending: 11/30/13

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	38,690	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	38,690	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	16,433	18,016	1,689	36,138	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,433	18,016	1,689	36,138	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.40%

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 1,493

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: 11/30/13 Fiscal Year: 11/30/13

* 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: 12/01/12 Ending: 11/30/13

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	331,195	18,264	6,933	356,392		356,392		356,392			1
2	Food Purchase		248,874		248,874		248,874	(5,761)	243,113			2
3	Housekeeping	75,765	8,749		84,514		84,514		84,514			3
4	Laundry	80,399	14,324		94,723		94,723		94,723			4
5	Heat and Other Utilities			116,936	116,936		116,936	(3,441)	113,495			5
6	Maintenance	87,253	23,270	74,810	185,333		185,333		185,333			6
7	Other (specify):*											7
8	**TOTAL General Services**	574,612	313,481	198,679	1,086,772		1,086,772	(9,202)	1,077,570			8
	B. Health Care and Programs											
9	Medical Director			900	900		900		900			9
10	Nursing and Medical Records	2,012,324	147,204	36,924	2,196,452		2,196,452		2,196,452			10
10a	Therapy											10a
11	Activities	64,659	8,264		72,923		72,923	(4,318)	68,605			11
12	Social Services	43,867		670	44,537		44,537		44,537			12
13	CNA Training											13
14	Program Transportation			3,946	3,946		3,946	(3,946)				14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,120,850	155,468	42,440	2,318,758		2,318,758	(8,264)	2,310,494			16
	C. General Administration											
17	Administrative	73,687			73,687		73,687		73,687			17
18	Directors Fees											18
19	Professional Services			15,588	15,588		15,588	(323)	15,265			19
20	Dues, Fees, Subscriptions & Promotions			6,801	6,801		6,801	(3,342)	3,459			20
21	Clerical & General Office Expenses	160,881	12,926	109,777	283,584		283,584	(66,343)	217,241			21
22	Employee Benefits & Payroll Taxes			1,024,103	1,024,103		1,024,103		1,024,103			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,794	7,794		7,794		7,794			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			67,356	67,356		67,356		67,356			26
27	Other (specify):*											27
28	**TOTAL General Administration**	234,568	12,926	1,231,419	1,478,913		1,478,913	(70,008)	1,408,905			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,930,030	481,875	1,472,538	4,884,443		4,884,443	(87,474)	4,796,969			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: 12/01/12 Ending: 11/30/13

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			288,138	288,138		288,138		288,138			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**			288,138	288,138		288,138		288,138			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	100,972	51,643	48,749	201,364		201,364		201,364			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			10,774	10,774		10,774	(10,774)				41
42	Provider Participation Fee			277,390	277,390		277,390		277,390			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	100,972	51,643	336,913	489,528		489,528	(10,774)	478,754			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,031,002	533,518	2,097,589	5,662,109		5,662,109	(98,248)	5,563,861			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: 12/01/12 Ending: 11/30/13

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	(5,761)	02		4
5	Telephone, TV & Radio in Resident Rooms	(3,441)	05		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	(60,928)	21		24
25	Fund Raising, Advertising and Promotional	(3,342)	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	(24,776)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (98,248)		$	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))**	$ (98,248)		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: 12/01/12

Ending: 11/30/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Transportation Revenue (To Extent of Expense)	$ (3,946)	14	1
2	Activity Revenue	(4,318)	11	2
3	Miscellaneous Revenue	(5,415)	21	3
4	Concenssion Revenue (To Extent of Expense)	(10,774)	41	4
5	Architect Fees	(323)	19	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**	(24,776)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hillcrest Home # 0001099 **Report Period Beginning:** 12/01/12 **Ending:** 11/30/13

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,761)	0	0	0	0	0	0	0	0	0	0	(5,761)	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	(3,441)	0	0	0	0	0	0	0	0	0	0	(3,441)	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**	(9,202)	0	0	0	0	0	0	0	0	0	0	(9,202)	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	(4,318)	0	0	0	0	0	0	0	0	0	0	(4,318)	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	(3,946)	0	0	0	0	0	0	0	0	0	0	(3,946)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(8,264)	0	0	0	0	0	0	0	0	0	0	(8,264)	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	(323)	0	0	0	0	0	0	0	0	0	0	(323)	19
20	Fees, Subscriptions & Promotions	(3,342)	0	0	0	0	0	0	0	0	0	0	(3,342)	20
21	Clerical & General Office Expenses	(66,343)	0	0	0	0	0	0	0	0	0	0	(66,343)	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**	(70,008)	0	0	0	0	0	0	0	0	0	0	(70,008)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(87,474)	0	0	0	0	0	0	0	0	0	0	(87,474)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Hillcrest Home # 0001099 **Report Period Beginning:** 12/01/12 **Ending:** 11/30/13

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	0	0	0	0	0	0	0	0	0	0	0	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**	0	0	0	0	0	0	0	0	0	0	0	0	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	(10,774)	0	0	0	0	0	0	0	0	0	0	(10,774)	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**	(10,774)	0	0	0	0	0	0	0	0	0	0	(10,774)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(98,248)	0	0	0	0	0	0	0	0	0	0	(98,248)	45

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/12 Ending: 11/30/13

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	$ 226,715	Henry County	100.00%	$ 226,715	$	1
2	V	22	IMRF	270,373	Henry County	100.00%	270,373		2
3	V	22	Workers Compensation	142,539	Henry County	100.00%	142,539		3
4	V	26	Property / Liability Insurance	67,356	Henry County	100.00%	67,356		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			$ 706,983			$ 706,983	$ *	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: 12/01/12 Ending: 11/30/13

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	Ann DeSmith	0.00%						3
4	Marvin Gradert	0.00%						4
5	JoAnne Hillman	0.00%						5
6	Rick Livesay	0.00%						6
7	Kathy Nelson	0.00%						7
8	Bill Preston	0.00%						8
9	Loren Rathjen	0.00%						9
10	Karen Urick	0.00%						10
11	Jacob Waller	0.00%						11
12	Tim Wells	0.00%						12
13	Dennis Anderson	0.00%						13
14	Jim Findley	0.00%						14
15	Roger Gradert	0.00%						15
16	James Kursock	0.00%						16
17	Jan May	0.00%						17
18	Tom May	0.00%						18
19	Don DeDobbelaere	0.00%						19
20	John Sovanski	0.00%						20
21	Ted Sturtevant	0.00%						21
22	Jerry Thompson	0.00%						22
23								23
24								24
25								25
26								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: 12/01/12 Ending: 11/30/13

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: 12/01/12 Ending: 11/30/13

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: 12/01/12 Ending: 11/30/13

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. **$** _____ **Line #** _____

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

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: 12/01/12 Ending: 11/30/13

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 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 2013 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:			
	2008		8
	2009		9
	2010		10
	2011		11
	2012		12

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

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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

2012 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 2012 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 2012.

	(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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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: 12/01/12 Ending: 11/30/13

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			$ 279,195	1
2					2
3	TOTALS			$ 279,195	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/12 Ending: 11/30/13

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	74,470						14
15	Various			1984	42,387						15
16	Various			1985	37,751						16
17	Various			1986	14,176						17
18	Various			1987	106,332						18
19	Various			1988	62,390						19
20	Various			1989	127,933						20
21	Various			1990	715,903						21
22	Various			1991	333,353						22
23	Various			1992	72,146						23
24	Various			1993	32,647						24
25	Various			1994	3,817						25
26	Various			1995	72,333						26
27	Various			1996	11,796						27
28	Various			1997	65,137						28
29	Various			1998	383,381						29
30	Various			1999	50,439						30
31	Various			2000	18,620						31
32	Various			2001	35,069						32
33	Various			2002	41,492						33
34	Various			2003	24,870						34
35	Various			2004	56,474						35
36	Various			2005	79,945						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: 12/01/12 Ending: 11/30/13

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	605,109						38
39	Various	2008	133,881						39
40	Various	2009	72,349						40
41									41
42	Courtyard Doors	2010	9,567						42
43	3 Rooftop A/C Units	2010	71,191						43
44	Resident Room Blinds	2010	694						44
45	Kitchen Project - Wall Construction / Vents / Lights	2010	1,418						45
46	Maintenance Building - Roof / Gutter/ Paint	2010	8,522						46
47	Well Pump - New Pump / Pipe / Wiring	2010	27,659						47
48	Pumphouse - Gutters / Siding / Doors	2010	6,162						48
49	Resident Rooms - Paint and Wall Paper / Base Cove / Stain	2010	19,384						49
50	Dining Rooms / Sitting Rooms - Doors / Paint / Chair Rail	2010	6,147						50
51	Pumphouse - Gutters / Siding / Doors	2010	2,561						51
52	Lighting - Hallways / Offices / Sitting Areas	2011	13,356						52
53	Doors and Door Alarms	2011	20,513						53
54	Maintenance Building - Roof / Gutter/ Paint	2011	14,980						54
55	Well Pump - Line Pipe	2011	2,597						55
56	S/E Med Room - Cabinets / Walls	2011	3,236						56
57	Construction - Main Entrance & Awning, Dining Room Exp.	2012	1,186,682						57
58	Construction - Main Entrance & Awning, Dining Room Exp.	2012	323						58
59	Generator Rebuild	2012	22,551						59
60	Elevator - Scavenger Pump	2013	3,869						60
61	Parking Lot - Asphalt and Lines Sprayed	2013	47,274						61
62	Concrete - East Dining Area	2013	17,739						62
63	Fire Alarm Panel	2013	19,955						63
64	Window Shades - Resident Rooms	2013	14,800						64
65	Elevator - Door Restrictor and Pit Ladder	2013	3,288						65
66	Well Project - Pump Replacement	2013	4,018						66
67									67
68									68
69	Financial Statement Depreciation			240,337		240,337		4,437,190	69
70	TOTAL (lines 4 thru 69)		$ 6,372,446	$ 240,337		$ 240,337	$	$ 4,437,190	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: 12/01/12 Ending: 11/30/13

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	$ 1,620,988	$ 31,179	$ 31,179	$	10	$ 851,363	71
72	Current Year Purchases	19,598	651	651		10	651	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,640,586	$ 31,830	$ 31,830	$		$ 852,014	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	$ 54,146	$ 4,682	$ 4,682	$	5	$ 35,693	76
77	Patient Transportation	Ford E-350 Shuttle Bus	2008	55,114	5,512	5,512		5	28,476	77
78	Patient Transportation	Chevy Silverado	2010	25,500	3,825	3,825		5	3,825	78
79	Patient Transportation	Grand Caravan	2013	39,046	1,952	1,952		5	1,952	79
80	TOTALS			$ 173,806	$ 15,971	$ 15,971	$		$ 69,946	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)	$ 8,466,033	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 288,138	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 288,138	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)	$ 5,359,150	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: 12/01/12 Ending: 11/30/13

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 [X] 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.	/2014	$
13.	/2015	$
14.	/2016	$

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: 12/01/12 Ending: 11/30/13

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	$ 31,635		$	$		$ 31,635	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			41,806			41,806	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	69,337					69,337	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				49,735		49,735	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					1,908		1,908	12
13	Other (specify): See Supplemental	39 - 03				6,943			6,943	13
14	TOTAL			$ 100,972		$ 48,749	$ 51,643		$ 201,364	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
12/01/12 - 11/30/13

Page 16 Supplemental Schedule

Description	Supplies	Other
Medical Supplies	1,344	
Therapy Supplies	564	
Lab / Radiology		6,943
Total	1,908	6,943

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/12 Ending: 11/30/13

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/13 (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	$ 2,316,952	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 20,000)	778,418		3
4	Supply Inventory (priced at Cost Basis)	31,915		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	305		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule	213		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,127,803	$	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	7,004,379		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,182,136		16
17	Accumulated Depreciation (book methods)	(5,359,150)		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 Schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,106,560	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,234,363	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 223,034	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	214,732		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	See Supplemental Schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 437,766	$	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	See 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)**	$ 437,766	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,796,597	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,234,363	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Hillcrest Home
Medicaid Cost Report
12/01/12 - 11/30/13

Page 17 Supplemental Schedule

Description	Operating	After Consolidation
Line 9 - Other Current Assets		
Accrued Interest	213	
Total	213	-
Line 23 - Other Long Term Assets		
Total	-	-
Line 36 - Other Current Liabilities		
Total	-	-
Line 43 - Other Long Term Liabilities		
Total	-	-

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/12 Ending: 11/30/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,697,389	1
2	Restatements (describe):		2
3	**PY Audit Adjustments**		3
4	**Post Employment Benefit Expense**	(6,487)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,690,902	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	105,695	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)**	$ 105,695	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)**	$ 5,796,597	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/12 Ending: 11/30/13

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	$ 4,709,926	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,709,926	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	89,442	6
7	Oxygen	29,009	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 118,451	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	20,615	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	34,768	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 55,383	23
	D. Non-Operating Revenue		
24	Contributions	61,611	24
25	Interest and Other Investment Income***	9,080	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 70,691	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	813,353	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 813,353	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,767,804	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,086,772	31
32	Health Care	2,318,758	32
33	General Administration	1,478,913	33
	B. Capital Expense		
34	Ownership	288,138	34
	C. Ancillary Expense		
35	Special Cost Centers	212,138	35
36	Provider Participation Fee	277,390	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,662,109	40
41	**Income before Income Taxes (line 30 minus line 40)****	105,695	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 105,695	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,101,348	44
45	Private Pay - Net Inpatient Revenue	1,993,731	45
46	Medicare - Net Inpatient Revenue	595,042	46
47	Other-(specify) Veterans - Net Inpatient Revenue	19,805	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,709,926	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.**

SEE ACCOUNTANTS' COMPILATION REPORT

Hillcrest Home
Medicaid Cost Report
12/01/12 - 11/30/13

Page 19 Supplemental Schedule

Description	Total	Page 5 Adjustment
Line 28 - Other Revenue		
FICA Reimbursement - Henry County (See Page 6)	226,715	
IMRF Reimbursement - Henry County (See Page 6)	270,373	
Ins. Reimbursement - Henry County (See Page 6)	209,895	
Transportation Income	10,537	10,537
Activity Income	4,318	4,318
Rent Income	11,100	
Miscellaneous Income	5,415	5,415
Farm Income	75,000	
Total	813,353	20,270

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/12 Ending: 11/30/13

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	1,330	1,856	$ 63,198	$ 34.05	1
2	Assistant Director of Nursing	1,727	2,080	64,851	31.18	2
3	Registered Nurses	15,252	17,135	377,465	22.03	3
4	Licensed Practical Nurses	19,235	22,117	407,716	18.43	4
5	CNAs & Orderlies	83,171	94,407	1,079,230	11.43	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	4,906	5,785	64,659	11.18	9
10	Activity Assistants					10
11	Social Service Workers	1,792	2,080	43,867	21.09	11
12	Dietician					12
13	Food Service Supervisor	1,788	2,080	34,448	16.56	13
14	Head Cook	3,341	4,169	48,386	11.61	14
15	Cook Helpers/Assistants					15
16	Dishwashers	21,968	24,743	248,361	10.04	16
17	Maintenance Workers	5,464	6,243	87,253	13.98	17
18	Housekeepers	6,801	7,853	75,765	9.65	18
19	Laundry	6,578	7,652	80,399	10.51	19
20	Administrator	1,822	2,080	73,687	35.43	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,806	11,121	160,881	14.47	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	1,523	1,800	19,864	11.04	31
32	Other Health Care(specify)					32
33	Other(specify) Therapists	3,410	3,678	100,972	27.45	33
34	TOTAL (lines 1 - 33)	189,914	216,879	$ 3,031,002 *	$ 13.98	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	157	$ 6,933	01 - 03	35
36	Medical Director	12	900	09 - 03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	7,326	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	8	670	12 - 03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	273	$ 15,829		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	5	$ 281	10 - 03	50
51	Licensed Practical Nurses	625	24,140	10 - 03	51
52	Certified Nurse Assistants/Aides	209	5,177	10 - 03	52
53	TOTAL (lines 50 - 52)	839	$ 29,598		53

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/12 Ending: 11/30/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mary Bergren	Administrator	0	$ 73,687
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 73,687

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
Kenyon & Associates	Architect	$ 323
Hesse Martone, PC	Legal	11,100
Jeremy Brune & Associates, LLC	Accounting	4,165
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 15,588

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 142,764
Unemployment Compensation Insurance	
FICA Taxes	226,715
Employee Health Insurance	348,182
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	295,651
Other Miscellaneous Benefits	10,791
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,024,103

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	793
Health Care Worker Background Check	1,924
(Indicate # of checks performed)	
Patient Background Checks	
Advertising	2,399
Public Relations	943
Dues	645
Subscriptions	97
Less: Public Relations Expense	(943)
Non-allowable advertising	(2,399)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,459

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,306
Seminar Expense	6,488
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,794

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Hillcrest Home
Medicaid Cost Report
12/01/12 - 11/30/13

Page 21 Supplemental Schedule - Legal Details

Vendor	Invoice Date	Amount	Allowable
Hesse Martone, PC	12/07/12	2,650	2,650
Hesse Martone, PC	01/04/13	1,150	1,150
Hesse Martone, PC	02/07/13	750	750
Hesse Martone, PC	05/07/13	900	900
Hesse Martone, PC	06/13/13	300	300
Hesse Martone, PC	08/06/13	1,200	1,200
Hesse Martone, PC	09/01/13	3,350	3,350
Hesse Martone, PC	09/10/13	800	800
		11,100	11,100
Page 5 Adjustments			-

Page 21 Supplemental Schedule - Seminar

Vendor	Invoice Date	Amount	Allowable
Genesis - Illini Campus	12/19/12	2	2
IH Mississippi Valley Credit Union	12/19/12	100	100
IH Mississippi Valley Credit Union	12/19/12	227	227
Ingenix	01/14/13	160	160
IH Mississippi Valley Credit Union	02/13/13	100	100
IH Mississippi Valley Credit Union	02/13/13	95	95
Genesis - Illini Campus	03/08/13	2	2
Ramirez Consulting Group	03/23/13	85	85
Ramirez Consulting Group	03/23/13	85	85
IH Mississippi Valley Credit Union	04/17/13	40	40
IH Mississippi Valley Credit Union	04/17/13	202	202
Eldercare Communications	05/01/13	92	92
Eldercare Communications	05/01/13	201	201
WPS Medicare	05/10/13	84	84
Nasco	05/23/13	131	131
Rudy Muzzarelli	05/30/13	600	600
Creative Forecasting, Inc.	06/08/13	60	60
IH Mississippi Valley Credit Union	08/14/13	380	380
IAPA	09/09/13	400	400
IH Mississippi Valley Credit Union	09/12/13	310	310
Hillcrest Home Petty Cash	09/17/13	17	17
Illinois ANFP	09/30/13	75	75
Motel Act Workshop	09/30/13	190	190
IH Mississippi Valley Credit Union	09/30/13	119	119
Freiberg Press, Inc.	10/03/13	120	120
INHAA	11/01/13	608	608
IH Mississippi Valley Credit Union	11/01/13	125	125
IH Mississippi Valley Credit Union	11/01/13	241	241
Pathway Health	11/12/13	880	880
Pathway Health	11/30/13	2,064	2,064
		7,794	7,794

Page 5 Adjustments -

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/12 Ending: 11/30/13

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 Home # 0001099 Report Period Beginning: 12/01/12 Ending: 11/30/13

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? **No**
If YES, give association name and amount. **N/A**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **54,537** 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 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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **277,390**
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? **Yes** Indicate the amount. $ **5,761**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100 Ln 14**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other 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 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