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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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 12/01/13 to 11/30/14 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

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/13 Ending: 11/30/14

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	17,766	16,956	2,043	36,765	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,766	16,956	2,043	36,765	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.02%

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 1,628

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: 11/30/14 Fiscal Year: 11/30/14

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

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/13 Ending: 11/30/14

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	340,075	22,811	5,284	368,170		368,170		368,170			1
2	Food Purchase		265,394		265,394		265,394	(5,539)	259,855			2
3	Housekeeping	75,930	15,585		91,515		91,515		91,515			3
4	Laundry	82,177	14,943		97,120		97,120		97,120			4
5	Heat and Other Utilities			134,355	134,355		134,355	(3,547)	130,808			5
6	Maintenance	92,051	20,823	156,196	269,070		269,070		269,070			6
7	Other (specify):* See Supplemental											7
8	TOTAL General Services	590,233	339,556	295,835	1,225,624		1,225,624	(9,086)	1,216,538			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	1,968,316	137,318	59,122	2,164,756		2,164,756		2,164,756			10
10a	Therapy											10a
11	Activities	66,303	7,786		74,089		74,089	(4,980)	69,109			11
12	Social Services	44,666		820	45,486		45,486		45,486			12
13	CNA Training											13
14	Program Transportation			6,957	6,957		6,957	(6,957)				14
15	Other (specify):* See Supplemental											15
16	TOTAL Health Care and Programs	2,079,285	145,104	68,099	2,292,488		2,292,488	(11,937)	2,280,551			16
	C. General Administration											
17	Administrative	80,340			80,340		80,340		80,340			17
18	Directors Fees											18
19	Professional Services			10,005	10,005		10,005	(100)	9,905			19
20	Dues, Fees, Subscriptions & Promotions			13,648	13,648		13,648	(3,651)	9,997			20
21	Clerical & General Office Expenses	151,659	12,764	108,253	272,676		272,676	(52,880)	219,796			21
22	Employee Benefits & Payroll Taxes			993,476	993,476		993,476		993,476			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,824	2,824		2,824		2,824			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			78,665	78,665		78,665		78,665			26
27	Other (specify):* See Supplemental											27
28	TOTAL General Administration	231,999	12,764	1,206,871	1,451,634		1,451,634	(56,631)	1,395,003			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,901,517	497,424	1,570,805	4,969,746		4,969,746	(77,654)	4,892,092			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
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: 12/01/13 Ending: 11/30/14

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			295,724	295,724		295,724	(9,225)	286,499			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):* See Supplemental											36
37	**TOTAL Ownership**			295,724	295,724		295,724	(9,225)	286,499			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	117,202	70,917	65,680	253,799		253,799		253,799			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			9,883	9,883		9,883	(9,883)				41
42	Provider Participation Fee			262,614	262,614		262,614		262,614			42
43	Other (specify):* See Supplemental											43
44	**TOTAL Special Cost Centers**	117,202	70,917	338,177	526,296		526,296	(9,883)	516,413			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,018,719	568,341	2,204,706	5,791,766		5,791,766	(96,762)	5,695,004			45

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

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/13 Ending: 11/30/14

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	(5,539)	02		4
5	Telephone, TV & Radio in Resident Rooms	(42)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(52,838)	21		24
25	Fund Raising, Advertising and Promotional	(3,651)	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	(34,692)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (96,762)		$	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))**	$ (96,762)		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

Hillcrest Home

ID# 0001099

Report Period Beginning: 12/01/13

Ending: 11/30/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Transportation Income (To Extent of Expense)	$ (6,957)	14	1
2	Activity Income	(4,980)	11	2
3	Rent Income	(9,225)	30	3
4	Cable	(3,547)	05	4
5	Concession Income (To Extent of Expense)	(9,883)	41	5
6	Legal - Non Allowable	(100)	19	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**	(34,692)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hillcrest Home # 0001099 **Report Period Beginning:** 12/01/13 **Ending:** 11/30/14

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	(5,539)	0	0	0	0	0	0	0	0	0	0	(5,539)	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	(3,547)	0	0	0	0	0	0	0	0	0	0	(3,547)	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**	(9,086)	0	0	0	0	0	0	0	0	0	0	(9,086)	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	(4,980)	0	0	0	0	0	0	0	0	0	0	(4,980)	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	(6,957)	0	0	0	0	0	0	0	0	0	0	(6,957)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(11,937)	0	0	0	0	0	0	0	0	0	0	(11,937)	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	(100)	0	0	0	0	0	0	0	0	0	0	(100)	19
20	Fees, Subscriptions & Promotions	(3,651)	0	0	0	0	0	0	0	0	0	0	(3,651)	20
21	Clerical & General Office Expenses	(52,880)	0	0	0	0	0	0	0	0	0	0	(52,880)	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**	(56,631)	0	0	0	0	0	0	0	0	0	0	(56,631)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(77,654)	0	0	0	0	0	0	0	0	0	0	(77,654)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Hillcrest Home # 0001099 **Report Period Beginning:** 12/01/13 **Ending:** 11/30/14

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(9,225)	0	0	0	0	0	0	0	0	0	0	(9,225)	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**	(9,225)	0	0	0	0	0	0	0	0	0	0	(9,225)	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	(9,883)	0	0	0	0	0	0	0	0	0	0	(9,883)	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**	(9,883)	0	0	0	0	0	0	0	0	0	0	(9,883)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(96,762)	0	0	0	0	0	0	0	0	0	0	(96,762)	45

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/13 Ending: 11/30/14

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	$ 228,198	Henry County	100.00%	$ 228,198	$	1
2	V	22	IMRF	274,037	Henry County	100.00%	274,037		2
3	V	22	Workers Compensation	133,331	Henry County	100.00%	133,331		3
4	V	26	Property / Liability Insurance	78,665	Henry County	100.00%	78,665		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			$ 714,231			$ 714,231	$ *	14

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

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/13 Ending: 11/30/14

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								3
4	Dennis Anderson							4
5	Jeff Orton							5
6	Ted Sturtevant							6
7	Jan May							7
8	Lynn Sutton							8
9	Kelli Parsons							9
10	Jo Anne Hillman							10
11	Jacob Waller							11
12	Steven Brandau							12
13	Lindi Kernan							13
14	Sheriff Padilla							14
15	Tim Wells							15
16	Ann DeSmith							16
17	Rick Livesay							17
18	Jim Findley							18
19	Loren Rathjen							19
20	Jerry Thompson							20
21	Bill Preston							21
22	Karen Urick							22
23	Marshall Jones							23
24	Jim Kursock							24
25	Kippy Breeden							25
26	Roger Gradert							26
27								27
28	There are no business transactions							28
29	between Henry County Board							29
30	Members and Hillcrest Home.							30

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/13 Ending: 11/30/14

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

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/13 Ending: 11/30/14

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

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/13 Ending: 11/30/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 0 Line # N/A

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

**** 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:** 12/01/13 **Ending:** 11/30/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 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 2014 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:			
	2009		8
	2010		9
	2011		10
	2012		11
	2013		12

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

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 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 2013 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 2013.

	(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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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: 12/01/13 Ending: 11/30/14

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).

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

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/13 Ending: 11/30/14

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	84		1971	1971	$ 220,795	$		$	$	$	4
5	22		1976	1976	1,064,182						5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1977	52,950						9
10	Various			1979	6,552						10
11	Various			1980	14,609						11
12	Various			1981	61,074						12
13	Various			1982	6,189						13
14	Various			1983	79,248						14
15	Various			1984	46,106						15
16	Various			1985	43,128						16
17	Various			1986	14,176						17
18	Various			1987	106,332						18
19	Various			1988	67,712						19
20	Various			1989	140,458						20
21	Various			1990	715,903						21
22	Various			1991	336,390						22
23	Various			1992	88,437						23
24	Various			1993	47,424						24
25	Various			1994	9,556						25
26	Various			1995	72,333						26
27	Various			1996	14,291						27
28	Various			1997	66,654						28
29	Various			1998	386,931						29
30	Various			1999	73,577						30
31	Various			2000	18,620						31
32	Various			2001	47,108						32
33	Various			2002	41,492						33
34	Various			2003	46,873						34
35	Various			2004	59,183						35
36	Various			2005	84,744						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

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/13 Ending: 11/30/14

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	$ 143,109	$		$	$	$	37
38	Various	2007	605,831						38
39	Various	2008	137,153						39
40	Various	2009	48,053						40
41	Various	2010	140,175						41
42									42
43	Lighting - Hallways / Offices / Sitting Areas - ****	2011	11,058						43
44	Doors and Door Alarms - ****	2011	20,254						44
45	Maintenance Building - Roof / Gutter/ Paint - ****	2011	10,467						45
46	Well Pump - Line Pipe	2011	2,597						46
47	S/E Med Room - Cabinets / Walls	2011	3,236						47
48	Generator Rebuild - ****	2012	22,367						48
49	Construction - Main Entrance & Awning, Dining Room Exp. - ***	2012	1,151,357						49
50	Elevator - Door Restrictor and Pit Ladder	2013	3,288						50
51	Window Shades - Resident Rooms - ****	2013							51
52									52
53	Building Improvements Added Post 06/30/13 Capital Projection								53
54									54
55	Elevator - Scavenger Pump	2013	3,869						55
56	Parking Lot - Asphalt and Lines Sprayed	2013	47,274						56
57	Concrete - East Dining Area	2013	17,739						57
58	Fire Alarm Panel	2013	19,955						58
59	Well Project - Pump Replacement	2013	4,018						59
60	Gutters / Drainage - Lower Level	2014	7,100						60
61	Fire Alarm Panel / Smoke Detectors - Annex, Kitchen, Hallway, L	2014	6,575						61
62	Roofing - Shingles, Drip Edge, and Freeze Barrier	2014	8,595						62
63	Water Heaters	2014	12,935						63
64									64
65	**** - Line items adjusted per 06/30/13 Capital Projection								65
66									66
67									67
68	Depreciation			286,499		286,499		5,654,874	68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,460,032	$ 286,499		$ 286,499	$	$ 5,654,874	70

**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: 12/01/13 Ending: 11/30/14

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	$ 1,640,586	$	$	$		$	71
72	Current Year Purchases	14,361						72
73	Fully Depreciated Assets							73
74	Disposals							74
75	TOTALS	$ 1,654,947	$	$	$		$	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	$	$	$		$	76
77	Patient Transportation	Ford E-350 Shuttle Bus	2008	55,114						77
78	Patient Transportation	Chevy Silverado	2010	25,500						78
79	Patient Transportation	Grand Caravan	2013	39,046						79
80	TOTALS			$ 173,806	$	$	$		$	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)	$ 8,567,980	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 286,499	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 286,499	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)	$ 5,654,874	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.

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/13 Ending: 11/30/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

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.	/2015	$
13.	/2016	$
14.	/2017	$

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 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.

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/13 Ending: 11/30/14

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.

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 / 39 - 03	hrs	$ 57,271		$ 287	$		$ 57,558	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			41,516			41,516	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	59,931					59,931	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				49,981		49,981	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					20,936		20,936	12
13	Other (specify): See Supplemental	39 - 03				23,877			23,877	13
14	TOTAL			$ 117,202		$ 65,680	$ 70,917		$ 253,799	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.

Hillcrest Home
Medicaid Cost Report
12/01/13 - 11/30/14

Page 16 Supplemental Schedule

Description	Supplies	Other
Medical Supplies	5,222	
Therapy Supplies	464	
Oxygen	15,250	
Lab / Radiology		23,877
Total	20,936	23,877

Facility Name & ID Number Hillcrest Home # 0001099 **Report Period Beginning:** 12/01/13 **Ending:** 11/30/14

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 11/30/14 **(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	$ 2,290,413	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 20,000)	801,325		3
4	Supply Inventory (priced at Cost - FIFO)	29,756		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	245		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule	194		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,121,933	$	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	7,026,649		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,209,432		16
17	Accumulated Depreciation (book methods)	(5,654,874)		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	367,130		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,227,532	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,349,465	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 201,521	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	207,268		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)**	$ 408,789	$	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)**	$ 408,789	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,940,676	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,349,465	$	48

***(See instructions.)**

Hillcrest Home
Medicaid Cost Report
12/01/13 - 11/30/14

Page 17 Supplemental Schedule

Description	Operating	After Consolidation
Line 9 - Other Current Assets		
Accrued Interest	194	
Total	194	-
Line 23 - Other Long Term Assets		
Construction in Progress	367,130	
Total	367,130	-
Line 36 - Other Current Liabilities		
Total	-	-
Line 43 - Other Long Term Liabilities		
Total	-	-

Facility Name & ID Number Hillcrest Home **#** 0001099 **Report Period Beginning:** 12/01/13 **Ending:** 11/30/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,796,597	1	
2	Restatements (describe):		2	
3	**PY Adjustment - Bad Debt Expense**	(13,699)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,782,898	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	157,778	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)**	$ 157,778	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)**	$ 5,940,676	24	*

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

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/13 Ending: 11/30/14

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	$ 4,856,722	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,856,722	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	103,727	6
7	Oxygen	15,250	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 118,977	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	21,791	14
15	Telephone, Television and Radio	42	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	43,936	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 65,769	23
	D. Non-Operating Revenue		
24	Contributions	40,526	24
25	Interest and Other Investment Income***	9,488	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 50,014	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	858,062	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 858,062	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,949,544	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,225,624	31
32	Health Care	2,292,488	32
33	General Administration	1,451,634	33
	B. Capital Expense		
34	Ownership	295,724	34
	C. Ancillary Expense		
35	Special Cost Centers	263,682	35
36	Provider Participation Fee	262,614	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,791,766	40
41	**Income before Income Taxes (line 30 minus line 40)****	157,778	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 157,778	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,384,552	44
45	Private Pay - Net Inpatient Revenue	1,798,990	45
46	Medicare - Net Inpatient Revenue	647,171	46
47	Other-(specify) Veterans - Net Inpatient Revenue	15,607	47
48	Other-(specify) Insurance - Net Inpatient Revenue	10,402	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,856,722	49

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

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

Hillcrest Home
Medicaid Cost Report
12/01/13 - 11/30/14

Page 19 Supplemental Schedule

Description	Total	Adjustment
Line 28 - Other Revenue		
Activity Income	4,980	4,980
Farm Income	119,515	
Rent Income	9,225	9,225
Transportation Income	10,337	6,957
FICA Reimbursement - Henry County	228,198	
IMRF Reimbursement - Henry County	274,037	
Insurance Reimbursement - Henry County	211,770	
Total	858,062	21,162

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/13 Ending: 11/30/14

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	1,724	2,080	$ 71,249	$ 34.25	1
2	Assistant Director of Nursing	1,797	2,080	66,625	32.03	2
3	Registered Nurses	15,278	17,277	389,807	22.56	3
4	Licensed Practical Nurses	20,146	23,113	396,225	17.14	4
5	CNAs & Orderlies	78,915	88,613	1,022,417	11.54	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,296	5,930	66,303	11.18	10
11	Social Service Workers	1,739	2,080	44,666	21.47	11
12	Dietician					12
13	Food Service Supervisor	1,840	2,080	35,588	17.11	13
14	Head Cook	3,877	4,578	53,647	11.72	14
15	Cook Helpers/Assistants	22,899	24,737	250,840	10.14	15
16	Dishwashers					16
17	Maintenance Workers	6,162	6,709	92,051	13.72	17
18	Housekeepers	6,929	7,827	75,930	9.70	18
19	Laundry	6,895	8,021	82,177	10.25	19
20	Administrator	2,120	2,512	80,340	31.98	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,194	10,299	151,659	14.73	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	1,764	2,026	21,993	10.86	31
32	Other Health Care(specify)					32
33	Other(specify) Therapists	4,046	4,198	117,202	27.92	33
34	TOTAL (lines 1 - 33)	190,621	214,160	$ 3,018,719 *	$ 14.10	34

* 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		$ 5,284	01 - 03	35
36	Medical Director		1,200	09 - 03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		7,740	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		820	12 - 03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 15,044		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 375	10 - 03	50
51	Licensed Practical Nurses		42,002	10 - 03	51
52	Certified Nurse Assistants/Aides		9,005	10 - 03	52
53	TOTAL (lines 50 - 52)		$ 51,382		53

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/13 Ending: 11/30/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mary Bergren	Administrator	0	$ 12,549
Lorna Brown	Administrator	0	67,791
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 80,340

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
Jeremy Brune & Associates, LLC	Accounting	$ 4,405
Hesse Martone, P.C.	Legal	5,600
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 10,005

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 133,331
Unemployment Compensation Insurance	
FICA Taxes	228,198
Employee Health Insurance	331,107
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	300,185
Other Employee Benefits	655
TOTAL (agree to Schedule V, line 22, col.8)	$ 993,476

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	$ 3,980
Advertising: Employee Recruitment	3,843
Health Care Worker Background Check	1,964
(Indicate # of checks performed)	
Patient Background Checks	
Advertising	2,902
Public Relations	750
Dues	100
Subscriptions	110
Less: Public Relations Expense	(750)
Non-allowable advertising	(2,902)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,997

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	338
Seminar Expense	2,486
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,824

* Attach copy of IMRF notifications

**See instructions.

Page 21 Supplemental Schedule - Legal Invoice Detail

Firm Name	Invoice Date	Description of Services	Total	Non-Allowable Amount
Hesse Martone, P.C.	12/09/13	Employee Union Organization - PP	100	100
Hesse Martone, P.C.	01/13/14	Employee Union Organization	150	
Hesse Martone, P.C.	02/10/14	Employee Union Organization	100	
Hesse Martone, P.C.	03/07/14	Employee Union Organization	1,450	
Hesse Martone, P.C.	04/09/14	Employee Union Organization	400	
Hesse Martone, P.C.	05/13/14	Employee Union Organization	450	
Hesse Martone, P.C.	07/31/14	Employee Union Organization	2,100	
Hesse Martone, P.C.	08/14/14	Employee Union Organization	250	
Hesse Martone, P.C.	11/17/14	Employee Union Organization	600	
Sub-Total			5,600	100

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/13 Ending: 11/30/14

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			$		$	$	$	$	$	$	$	$	$
2	N/A												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/13 Ending: 11/30/14

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. $ **55,649** 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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **262,614**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **21,791**

(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) Has a schedule for the legal fees reported on the cost report been provided by the facility? **Yes**
See page 39 of the instructions for details.
Attach invoices and a summary of services for all architect and appraisal fees