		FOR BHF USE					

LL1

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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 Highway 82 (Number) — Geneseo (City) — 61254 (Zip Code)

County: Henry

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

HFS ID Number:

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

Type of Ownership:

- [ ] VOLUNTARY,NON-PROFIT
  - [ ] Charitable Corp.
  - [ ] Trust
  - IRS Exemption Code
- [ ] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [X] GOVERNMENTAL
  - [ ] State
  - [X] County
  - [ ] 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 12/01/19 to 11/30/20 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)	Janet Holmberg
	(Title)	Administrator
Paid Preparer	(Signed)	(Date)
	(Print Name and Title)	Jeremy M. Brune, CPA Chief Executive Officer
	(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' PREPARATION REPORT

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/19 Ending: 11/30/20

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

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

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	15,374	16,099	1,332	32,805	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,374	16,099	1,332	32,805	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.56%

D. How many bed reserve days during this year were paid by the Department? 0 (Do not include bed reserve 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 744

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: 11/30/20 Fiscal Year: 11/30/20

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number: Hillcrest Home # 0001099 Report Period Beginning: 12/01/19 Ending: 11/30/20

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	490,469	31,481	8,078	530,027		530,027		530,027			1
2	Food Purchase		295,294		295,294		295,294	(1,391)	293,903			2
3	Housekeeping	112,106	27,728		139,834		139,834		139,834			3
4	Laundry	98,276	10,952		109,228		109,228		109,228			4
5	Heat and Other Utilities			102,178	102,178		102,178	(12,594)	89,584			5
6	Maintenance	145,383	25,765	126,472	297,620		297,620	(10,200)	287,420			6
7	Other (specify):* See Supplemental											7
8	**TOTAL General Services**	846,234	391,220	236,727	1,474,180		1,474,180	(24,185)	1,449,995			8
	B. Health Care and Programs											
9	Medical Director			6,900	6,900		6,900		6,900			9
10	Nursing and Medical Records	2,036,216	136,552	453,053	2,625,821		2,625,821		2,625,821			10
10a	Therapy	74,718			74,718		74,718		74,718			10a
11	Activities	87,130	4,120		91,249		91,249	(3,047)	88,202			11
12	Social Services	43,464	54	1,335	44,853		44,853		44,853			12
13	CNA Training											13
14	Program Transportation			2,889	2,889		2,889	(1,413)	1,476			14
15	Other (specify):* See Supplemental											15
16	**TOTAL Health Care and Programs**	2,241,527	140,725	464,177	2,846,429		2,846,429	(4,460)	2,841,969			16
	C. General Administration											
17	Administrative	79,193			79,193		79,193		79,193			17
18	Directors Fees											18
19	Professional Services			11,525	11,525		11,525		11,525			19
20	Dues, Fees, Subscriptions & Promotions			14,904	14,904		14,904	(1,734)	13,170			20
21	Clerical & General Office Expenses	194,214	12,504	113,743	320,461		320,461	(33,209)	287,252			21
22	Employee Benefits & Payroll Taxes			1,031,063	1,031,063		1,031,063		1,031,063			22
23	Inservice Training & Education			2,689	2,689		2,689		2,689			23
24	Travel and Seminar			2,813	2,813		2,813		2,813			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			87,694	87,694		87,694		87,694			26
27	Other (specify):* See Supplemental											27
28	**TOTAL General Administration**	273,406	12,504	1,264,432	1,550,342		1,550,342	(34,943)	1,515,399			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,361,167	544,448	1,965,336	5,870,952		5,870,952	(63,588)	5,807,364			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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			252,660	252,660		252,660	(11,385)	241,275			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			252,660	252,660		252,660	(11,385)	241,275			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	165,996	48,214	47,344	261,554		261,554		261,554			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			12,990	12,990		12,990	(12,990)	0			41
42	Provider Participation Fee			251,645	251,645		251,645		251,645			42
43	Other (specify):* See Supplemental											43
44	TOTAL Special Cost Centers	165,996	48,214	311,979	526,189		526,189	(12,990)	513,199			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,527,164	592,662	2,529,975	6,649,801		6,649,801	(87,963)	6,561,838			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/19 Ending: 11/30/20

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	(1,391)	02		4
5	Telephone, TV & Radio in Resident Rooms	(12,594)	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	(11,385)	30		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	(33,209)	21		24
25	Fund Raising, Advertising and Promotional	(1,734)	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	(27,650)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (87,963)		$	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))**	$ (87,963)		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' PREPARATION REPORT

STATE OF ILLINOIS

Hillcrest Home

ID# 0001099

Report Period Beginning: 12/01/19

Ending: 11/30/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Transportation Income	$ (1,413)	14	1
2	Activity Income	(3,047)	11	2
3	Rent Income	(10,200)	06	3
4	Concession Income	(12,990)	41	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				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**	(27,650)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/19 Ending: 11/30/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,391)	0	0	0	0	0	0	0	0	0	0	(1,391)	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	(12,594)	0	0	0	0	0	0	0	0	0	0	(12,594)	5
6	Maintenance	(10,200)	0	0	0	0	0	0	0	0	0	0	(10,200)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(24,185)	0	0	0	0	0	0	0	0	0	0	(24,185)	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	(3,047)	0	0	0	0	0	0	0	0	0	0	(3,047)	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	(1,413)	0	0	0	0	0	0	0	0	0	0	(1,413)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(4,460)	0	0	0	0	0	0	0	0	0	0	(4,460)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(1,734)	0	0	0	0	0	0	0	0	0	0	(1,734)	20
21	Clerical & General Office Expenses	(33,209)	0	0	0	0	0	0	0	0	0	0	(33,209)	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**	(34,943)	0	0	0	0	0	0	0	0	0	0	(34,943)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(63,588)	0	0	0	0	0	0	0	0	0	0	(63,588)	29

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(11,385)	0	0	0	0	0	0	0	0	0	0	(11,385)	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**	(11,385)	0	0	0	0	0	0	0	0	0	0	(11,385)	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	(12,990)	0	0	0	0	0	0	0	0	0	0	(12,990)	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**	(12,990)	0	0	0	0	0	0	0	0	0	0	(12,990)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(87,963)	0	0	0	0	0	0	0	0	0	0	(87,963)	45

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/19 Ending: 11/30/20

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	100.00%					

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	IMRF	$ 299,683	Henry County	100.00%	$ 299,683	$	1
2	V	22	FICA	262,112	Henry County	100.00%	262,112		2
3	V	22	FUTA		Henry County	100.00%			3
4	V	22	Workers Compensation	85,394	Henry County	100.00%	85,394		4
5	V	26	Property / Casualty Insurance	87,694	Henry County	100.00%	87,694		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			$ 734,883			$ 734,883	$ *	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/19 Ending: 11/30/20

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								1
2	Board of Directors - Henry County							2
3								3
4	Kippy Breeden							4
5	Mark Burton							5
6	Jill Darin							6
7	Ray Elliott							7
8	Angie Frank							8
9	Joseph Garrity							9
10	Kathy Nelson							10
11	Jeffery Orton							11
12	Bill Preston							12
13	James Thompson							13
14	Dwayne Anderson							14
15	Natalie Collins							15
16	Marshall Jones							16
17	Shawn Kendall							17
18	Jan May							18
19	Jim Padilla							19
20	Kelli Parsons							20
21	Ned Richardson							21
22	Mallisa Sandberg							22
23	Lynn Sutton							23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/19 Ending: 11/30/20

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1									$		1
2	N/A										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' PREPARATION REPORT

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/19 Ending: 11/30/20

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' PREPARATION REPORT

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/19 Ending: 11/30/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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

SEE ACCOUNTANTS' PREPARATION 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: 12/01/19 Ending: 11/30/20

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2019 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 2020 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:

Year	Amount	Line
2015		**8**
2016		**9**
2017		**10**
2018		**11**
2019		**12**

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

N/A - Hillcrest Home is exempt from real estate taxes.

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' PREPARATION REPORT

2019 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 2019 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 2019.

	(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 X 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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 12/01/19 Ending: 11/30/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 69,394 B. General Construction Type: Exterior Brick Masonry 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility			$ 295,782	1
2					2
3	TOTALS			$ 295,782	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/19 Ending: 11/30/20

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	$	50	$ 4,416	$ 4,416	$	4
5	22		1976	1976	1,064,182	21,283	50	21,283		952,943	5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1977	52,950	1,059	50	1,059		46,596	9
10	Various			1979	6,552		50				10
11	Various			1980	14,609	292	50	292		11,833	11
12	Various			1981	61,074	1,221	50	1,221		48,246	12
13	Various			1982	6,189		50				13
14	Various			1983	79,248	930	20-50	930		47,367	14
15	Various			1984	46,106	848	50	848		30,944	15
16	Various			1985	43,128	755	50	755		30,200	16
17	Various			1986	14,176		20-30			14,176	17
18	Various			1987	106,332		30			106,332	18
19	Various			1988	67,712		12-20			7,056	19
20	Various			1989	140,458	74	20-40	74		55,253	20
21	Various			1990	715,903		20-25			702,566	21
22	Various			1991	336,390		5-20			307,262	22
23	Various			1992	88,437		5-20			4,763	23
24	Various			1993	47,424		5-20			18,731	24
25	Various			1994	9,556		10-20			7,853	25
26	Various			1995	72,333	77	20-40	77		56,318	26
27	Various			1996	14,291		5-20			3,119	27
28	Various			1997	66,654	383	5-40	383		65,966	28
29	Various			1998	386,931		10-20			373,421	29
30	Various			1999	73,577		10-20			49,155	30
31	Various			2000	18,620		10			7,401	31
32	Various			2001	47,108		10			36,455	32
33	Various			2002	41,492		10			36,275	33
34	Various			2003	46,873		10			5,347	34
35	Various			2004	59,183		10			55,195	35
36	Various			2005	84,744		10			59,348	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' PREPARATION REPORT

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/19 Ending: 11/30/20

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	$	10	$	$	$ 72,627	37
38	Various	2007	605,831		10			604,580	38
39	Various	2008	137,153		10			110,708	39
40	Various	2009	48,053		10			46,366	40
41	Various	2010	140,175	5,688	10	14,018	8,330	143,163	41
42	Various	2011	47,612	5,469	10	201	(5,268)	51,552	42
43	Various	2012	1,173,724	23,474	50	23,474		195,804	43
44	Various	2013	96,143	9,615	10	9,615		69,361	44
45	Various	2014	35,205	2,228	10	3,521	1,293	14,707	45
46	Various	2015	653,984	38,457	10-50	38,457		205,894	46
47	Various	2016	251,805	25,180	10	25,180		110,284	47
48	Sprinkler Tank Project (New Tank)	2017	8,823	882	10	882		3,087	48
49	2 RTU Air Conditioning Units	2017	31,376	3,138	10	3,138		10,721	49
50	Gas Line Project (Gas Line and Meter)	2017	22,944	2,294	10	2,294		6,882	50
51	Sewage Grinder (Installation)	2017	11,382	1,138	10	1,138		3,414	51
52	Ambulance Entrance & Ramp Addition								52
53	Architecture and Construction	2018	186,619	7,465	25	7,465		7,465	53
54	Water Pump (Motor, Gaskets, Seal, and Sleave)	2018	22,373	4,475	5	4,475		4,475	54
55	Activty & Therapy Room Addition								55
56	Architecture and Construction	2018	1,156,474	23,129	50	23,129		23,129	56
57	Laundry Room Air Conditioning	2018	20,945	2,095	10	2,095		2,095	57
58	New Building - Maintenance	2020	333,979	943	10-50	943		943	58
59	Sewer Line Replacement - Under Basement Floor	2020	12,036	1,103	10	1,103		1,103	59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69	Non-Scheduled HFS Assets			20,155			(20,155)		69
70	TOTAL (lines 4 thru 69)		$ 9,172,772	$ 203,850		$ 192,465	$ (11,385)	$ 4,828,481	70

SEE ACCOUNTANTS' PREPARATION 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: 12/01/19 Ending: 11/30/20

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	$ 473,471	$ 37,049	$ 37,049	$	5 - 10	$ 341,037	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 473,471	$ 37,049	$ 37,049	$		$ 341,037	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 / Trucks / Bus	Various	$ 99,464	$	$	$	5	$ 99,494	76
77	Patient Transportation	Van	2015	40,337	1,345	1,345		5	40,337	77
78	Patient Transportation	Bus / Van	2019	87,090	9,192	9,192		5	17,418	78
79	Patient Transportation	Truck	2020	49,426	1,224	1,224		5	1,224	79
80	TOTALS			$ 276,317	$ 11,761	$ 11,761	$		$ 158,473	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)	$ 10,218,342	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 252,660	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 241,275	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (11,385)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,327,991	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/19 Ending: 11/30/20

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.	/2021	$
13.	/2022	$
14.	/2023	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ Description: N/A

(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' PREPARATION REPORT

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/19 Ending: 11/30/20

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' PREPARATION 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 Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 01	hrs	$ 73,291		$	$		$ 73,291	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			42,953			42,953	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	92,705					92,705	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				29,185		29,185	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					19,029		19,029	12
13	Other (specify): See Supplemental	39 - 03				4,391			4,391	13
14	TOTAL			$ 165,996		$ 47,344	$ 48,214		$ 261,554	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' PREPARATION REPORT

Hillcrest Home
Medicaid Cost Report
12/01/19 - 11/30/20

Page 16 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Medical Supplies		8,620		8,620
Oxygen		10,409		10,409
Laboratory / Radiology			4,391	4,391
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
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				-
				-
				-
				-
Total	-	19,029	4,391	23,420

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/19 Ending: 11/30/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/20 (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	$ 2,468,412	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 20,000)	447,159		3
4	Supply Inventory (priced at Cost -FIFO)	50,304		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	365		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental	1,438		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,967,678	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	295,782		13
14	Buildings, at Historical Cost	9,322,430		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	739,188		16
17	Accumulated Depreciation (book methods)	(6,162,006)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental	9,942		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,205,336	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,173,014	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 175,160	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	227,575		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	660,383		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,063,118	$	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			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,063,118	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 6,109,896	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,173,014	$	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Hillcrest Home
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Page 17 Supplemental Schedule

Description	Operating	Building	Total
Line 9 - Other Current Assets			
Accrued Interest	1,438		1,438
			-
			-
			-
			-
Sub-Total	1,438	-	1,438
Line 23 - Long Term Assets			
Construction in Progress	9,942		9,942
			-
			-
			-
			-
Sub-Total	9,942	-	9,942
Line 36 - Other Current Liability			
Net Pension Liability	660,383		660,383
			-
			-
			-
			-
Sub-Total	660,383	-	660,383
Line 43 - Long term Liabilities			
			-
			-
			-
			-
			-
Sub-Total	-	-	-

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/19 Ending: 11/30/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,834,271	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,834,271	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	275,626	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)**	$ 275,626	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)**	$ 6,109,896	24 *

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

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Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/19 Ending: 11/30/20

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,276,217	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,276,217	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	110,677	6
7	Oxygen	10,409	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 121,086	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	18,756	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,391	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	24,132	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 44,279	23
	D. Non-Operating Revenue		
24	Contributions	46,719	24
25	Interest and Other Investment Income***	23,491	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 70,211	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental	1,413,633	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,413,633	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,925,427	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,474,180	31
32	Health Care	2,846,429	32
33	General Administration	1,550,342	33
	B. Capital Expense		
34	Ownership	252,660	34
	C. Ancillary Expense		
35	Special Cost Centers	274,544	35
36	Provider Participation Fee	251,645	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,649,801	40
41	**Income before Income Taxes (line 30 minus line 40)****	275,626	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 275,626	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,680,599	44
45	Private Pay - Net Inpatient Revenue	2,128,601	45
46	Medicare - Net Inpatient Revenue	383,288	46
47	Other-(specify) Veterans - Net Inpatient Revenue	52,103	47
48	Other-(specify) Insurance - Net Inpatient Revenue	31,627	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,276,217	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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Description	Amount	Total
Transportation Income	1,413	1,413
Activity Income	3,047	3,047
Rent Income	10,200	10,200
FICA Reimbursement (Henry Co.)	262,112	262,112
IMRF Reimbursement (Henry Co.)	281,166	281,166
Insurance Reimbursement (Henry Co.)	172,863	172,863
HHS - Cares Act Funds	620,062	620,062
HFS - Cares Act Funds	62,770	62,770
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
Total	1,413,633	1,413,633

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/19 Ending: 11/30/20

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,884	2,080	$ 80,591	$ 38.75	1
2	Assistant Director of Nursing	1,818	2,080	57,809	27.79	2
3	Registered Nurses	7,088	8,171	233,248	28.55	3
4	Licensed Practical Nurses	23,885	26,642	625,079	23.46	4
5	CNAs & Orderlies	50,541	55,673	873,543	15.69	5
6	CNA Trainees					6
7	Licensed Therapist	5,209	5,209	165,996	31.87	7
8	Rehab/Therapy Aides	1,864	2,080	74,718	35.92	8
9	Activity Director					9
10	Activity Assistants	5,338	6,056	87,130	14.39	10
11	Social Service Workers	2,016	2,144	43,464	20.27	11
12	Dietician					12
13	Food Service Supervisor	1,753	1,869	45,818	24.51	13
14	Head Cook	5,918	6,900	103,301	14.97	14
15	Cook Helpers/Assistants	25,379	27,989	341,350	12.20	15
16	Dishwashers					16
17	Maintenance Workers	6,771	8,088	145,383	17.98	17
18	Housekeepers	7,527	8,991	112,106	12.47	18
19	Laundry	7,046	8,076	98,276	12.17	19
20	Administrator	2,016	2,296	79,193	34.49	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,061	11,077	194,214	17.53	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	4,287	5,097	80,995	15.89	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	3,318	3,579	84,950	23.74	33
34	TOTAL (lines 1 - 33)	173,719	194,097	$ 3,527,164 *	$ 18.17	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		$ 8,078	01 - 03	35
36	Medical Director		6,900	09 - 03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				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		1,335	12 - 03	45
46	Other(specify) See Supplemental				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 16,313		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		$ 11,654	10 - 03	50
51	Licensed Practical Nurses		51,254	10 - 03	51
52	Certified Nurse Assistants/Aides		328,307	10 - 03	52
53	TOTAL (lines 50 - 52)		$ 391,215		53

Hillcrest Home
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Page 20 Supplemental Schedule

Description	CC Reference	Hours Worked	Hours Paid	Salary	Average Rate		Hours Paid	Contracted Cost
Nursing Home Employees								
Care Plan Coordinator	10	3,318	3,579	84,950	23.74			
					-			
					-			
					-			
					-			
					-			
					-			
					-			
					-			
					-			
					-			
					-			
					-			
Total		3,318	3,579	84,950	23.74			
Contracted Services								
N/A								
Total							-	-

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/19 Ending: 11/30/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Janet Holmberg	Administrator	0	$ 79,193
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 79,193

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 & Assoc., LLC	Accounting	$ 4,050
Hesse Martone, P.C.	Legal	7,475
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 11,525

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 85,394
Unemployment Compensation Insurance	
FICA Taxes	262,112
Employee Health Insurance	364,706
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	302,477
Other Benefits	16,374
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,031,063

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	7,164
Health Care Worker Background Check	1,434
(Indicate # of checks performed)	
Patient Background Checks	
Licenses	1,990
Dues	592
Advertising	1,201
Public Relations	533
Less: Public Relations Expense	(533)
Non-allowable advertising	(1,201)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,170

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,813
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,813

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Hillcrest Home
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Page 21 Supplemental Schedule - Legal Invoice Detail

Vendor	Service Description	Invoice Date		Amount	Non-Allowable	Allowable
Hesse Martone, P.C.	General Labor	05/04/20		1,125		1,125
Hesse Martone, P.C.	General Labor	08/05/20		663		663
Hesse Martone, P.C.	General Labor	09/08/20		63		63
Hesse Martone, P.C.	Labor Negotiations	10/13/20		625		625
Hesse Martone, P.C.	Labor Negotiations	11/09/20		5,000		5,000
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
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						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
Total				7,475	-	7,475

Facility Name & ID Number **Hillcrest Home** **# 0001099** **Report Period Beginning: 12/01/19 Ending: 11/30/20**

XX. GENERAL INFORMATION:

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

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

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **39,536** 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. $ **251,645**
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' PREPARATION 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. $ **1,391**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **Ln. 14**
d. Have vehicle usage logs been maintained? **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: **Lauterbach & Amen, LLP (Not Final)**

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

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