FOR BHF USE

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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: 0025239

Facility Name: Rolling Hills Manor

Address: 3615 16th Street (Number) Zion (City) 60099 (Zip Code)

County: Lake

Telephone Number: (847) 746-8382 **Fax #** (847) 746-3545

HFS ID Number:

Date of Initial License for Current Owners: 9/1/1979

Type of Ownership:

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

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: Amanda Springborn **Telephone Number:** (314) 925-3838
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 11/1/19 to 10/31/20 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) Christine Hill
(Title) Executive Director

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address) RSM US LLP, 20 N. Martingale Road, Ste. 500 Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847)517-7067

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 Rolling Hills Manor # 0025239 Report Period Beginning: 11/1/19 Ending: 10/31/20

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 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	115	Skilled (SNF)	115	42,090	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	115	TOTALS	115	42,090	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	15,831	11,826	6,746	34,403	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,831	11,826	6,746	34,403	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.74%

D. How many bed reserve days during this year were paid by the Department?
None (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)
None

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] Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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 9/1/1979

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 9/1/1979 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 115 and days of care provided 6,481

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: 10/31/2020 Fiscal Year: 10/31/2020

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

Facility Name & ID Number Rolling Hills Manor # 0025239 Report Period Beginning: 11/1/19 Ending: 10/31/20

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	440,247	30,165	39,764	510,176		510,176		510,176			1
2	Food Purchase		278,788		278,788		278,788	(3,465)	275,323			2
3	Housekeeping	322,816	66,473	-	389,289		389,289		389,289			3
4	Laundry	210,797	35,202	-	245,999		245,999		245,999			4
5	Heat and Other Utilities			194,571	194,571		194,571		194,571			5
6	Maintenance	232,013	11,440	98,114	341,567		341,567	3,925	345,492			6
7	Other (specify):*	-	-	-								7
8	TOTAL General Services	1,205,873	422,068	332,449	1,960,390		1,960,390	460	1,960,850			8
	B. Health Care and Programs											
9	Medical Director	-	-	24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	4,085,432	273,582	208,706	4,567,720		4,567,720		4,567,720			10
10a	Therapy	164,156	4,340	3,000	171,496		171,496		171,496			10a
11	Activities	92,893	9,272	7,062	109,227		109,227	(40)	109,187			11
12	Social Services	102,898	290	-	103,188		103,188		103,188			12
13	CNA Training	-	-	-								13
14	Program Transportation	-	-	20,598	20,598		20,598		20,598			14
15	Other (specify):*	-	-	-								15
16	TOTAL Health Care and Programs	4,445,379	287,484	263,366	4,996,229		4,996,229	(40)	4,996,189			16
	C. General Administration											
17	Administrative	70,744	-	-	70,744		70,744		70,744			17
18	Directors Fees			17,800	17,800		17,800		17,800			18
19	Professional Services			232,369	232,369		232,369	(14,852)	217,517			19
20	Dues, Fees, Subscriptions & Promotions			69,358	69,358		69,358	(2,076)	67,282			20
21	Clerical & General Office Expenses	547,481	44,891	74,857	667,229		667,229	(3,928)	663,301			21
22	Employee Benefits & Payroll Taxes			1,101,322	1,101,322		1,101,322		1,101,322			22
23	Inservice Training & Education			6,700	6,700		6,700		6,700			23
24	Travel and Seminar			14	14		14		14			24
25	Other Admin. Staff Transportation		-	591	591		591		591			25
26	Insurance-Prop.Liab.Malpractice			304,222	304,222		304,222		304,222			26
27	Other (specify):*			-								27
28	TOTAL General Administration	618,225	44,891	1,807,233	2,470,349		2,470,349	(20,856)	2,449,493			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,269,477	754,443	2,403,048	9,426,968		9,426,968	(20,436)	9,406,532			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 Rolling Hills Manor #0025239 Report Period Beginning: 11/1/19 Ending: 10/31/20

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger: Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			253,574	253,574		253,574	24,383	277,957			30
31	Amortization of Pre-Op. & Org.			-								31
32	Interest			102,275	102,275		102,275	(2,669)	99,606			32
33	Real Estate Taxes			-								33
34	Rent-Facility & Grounds			-								34
35	Rent-Equipment & Vehicles			153,502	153,502		153,502		153,502			35
36	Other (specify):*			-								36
37	**TOTAL Ownership**			509,351	509,351		509,351	21,714	531,065			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-								38
39	Ancillary Service Centers	-	254,850	941,938	1,196,788		1,196,788		1,196,788			39
40	Barber and Beauty Shops	-	-	447	447		447	(447)				40
41	Coffee and Gift Shops	-	-	-								41
42	Provider Participation Fee			217,978	217,978		217,978		217,978			42
43	Other (specify):* Non-Allowable Cos	65,026	-	234,258	299,284		299,284	(299,284)				43
44	**TOTAL Special Cost Centers**	65,026	254,850	1,394,621	1,714,497		1,714,497	(299,731)	1,414,766			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,334,503	1,009,293	4,307,020	11,650,816		11,650,816	(298,453)	11,352,363			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 Rolling Hills Manor # 0025239 Report Period Beginning: 11/1/19 Ending: 10/31/20

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	(3,063)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	24,383	30		9
10	Interest and Other Investment Income	(2,669)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,239)	43		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	(14,852)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(188,457)	43		24
25	Fund Raising, Advertising and Promotional	(11,443)	43		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 PG5A	(100,113)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (298,453)		$	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))	$ (298,453)		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.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			$		47

Rolling Hills Manor

ID# 0025239

Report Period Beginning: 11/1/19

Ending: 10/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Nonallowable marketing salary	$ (65,026)	43	1
2	Labs - Part A	(12,691)	43	2
3	X-Rays - Part A	(14,002)	43	3
4	Offset Vending Machine revenue	(402)	2	4
5	Late Payment fees	(2,866)	43	5
6	Christmas Gifts	(695)	43	6
7	Resident and Family Parties	(1,498)	43	7
8	Miscellaneous Income	(3,928)	21	8
9	Beauty Shop	(447)	40	9
10	Other revenue - Activities/Outings	(40)	11	10
11	Reclass Repairs & Maintenance	3,925	6	11
12	Offset Lobbying Expense	(2,076)	20	12
13	Laboratory-Non Medicare	(242)	43	13
14	Donations- Charitable	(125)	43	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**	(100,113)		49

Facility Name & ID Number Rolling Hills Manor # 0025239 Report Period Beginning: 11/1/19 Ending: 10/31/20

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
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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. [ ] YES [X] 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		N/A	$			$	$	1
2	V								2
3	V								3
4	V								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			$			$	$ * 0	14

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

Facility Name & ID Number Rolling Hills Manor # 0025239 Report Period Beginning: 11/1/19 Ending: 10/31/20

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	Slovak American Charitable Association	100%	N/A		Slovak American Char	Zion, IL	Restricted Holding I	1
2					Rolling Hills Place	Zion, IL	Assisted Living	2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
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27								27
28								28
29								29
30								30

Facility Name & ID Number Rolling Hills Manor # 0025239 Report Period Beginning: 11/1/19 Ending: 10/31/20

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	
	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	Steve Fusek	Director	Vice President	0	0	0.5	2%	Director Fee	$ 2,543	L18, C3	1
2	Janet Pilch	Director	Treasurer	0	0	0.5	2%	Director Fee	2,543	L18, C3	2
3	Anne Scott	Director	Mgmt Committee	0	0	0.5	2%	Director Fee	2,543	L18, C3	3
4	Dorothy Mitchell	Director	Secretary	0	0	0.5	2%	Director Fee	2,543	L18, C3	4
5	Jim Stefo, Jr.	Director	President	0	0	0.5	2%	Director Fee	2,543	L18, C3	5
6	Andrew Stefo	Director	Mgmt Committee	0	0	0.5	2%	Director Fee	2,543	L18, C3	6
7	Bryan Ipsen	Director	Mgmt Committee	0	0	0.5	2%	Director Fee	2,543	L18, C3	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 17,800		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 Rolling Hills Manor # 0025239 Report Period Beginning: 11/1/19 Ending: 10/31/20

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 N/A
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		N/A				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
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17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Rolling Hills Manor # 0025239 Report Period Beginning: 11/1/19 Ending: 10/31/20

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** 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	Illinois Finance Authority		X	Bonds Payable	$8,700	5/28/2010	$ 2,600,000	$ 1,583,780	6/1/2034	3.5	$ 49,150	1
2	Revenue Bonds											2
3												3
4												4
5												5
	Working Capital											
6	Fifth Third Bank		X	Line of Credit	Interest Only	6/5/2019	1,500,000	1,250,000	6/5/2022	4.25	53,125	6
7	Fifth Third Bank (PPP)		X	Line of Credit	$96,947	5/1/2020	1,731,300	1,731,300	4/30/2022	1.00	-	7
8	SBA Loan		X	Line of Credit	$641	8/19/2020	150,000	150,000	8/18/2050	2.75	-	8
9	TOTAL Facility Related				$106,287.58		$ 5,981,300	$ 4,715,080			$ 102,275	9
	B. Non-Facility Related*											
10									Offset Interest Income		(61)	10
11									Offset Finance Charges		(2,608)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (2,669)	14
15	TOTALS (line 9+line14)						$ 5,981,300	$ 4,715,080			$ 99,606	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A 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 Rolling Hills Manor # 0025239 Report Period Beginning: 11/1/19 Ending: 10/31/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 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 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.)**	**Alloc. Fr. Mgmt. Co.**	$	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:			
	2015		8
	2016		9
	2017		10
	2018		11
	2019		12

Facility is non-profit organization.

	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

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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rolling Hills Manor COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0025239

CONTACT PERSON REGARDING THIS REPORT Christine Hill

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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 N/A 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 Rolling Hills Manor # 0025239 Report Period Beginning: 11/1/19 Ending: 10/31/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,632 B. General Construction Type: Exterior Brick Frame N/A Number of Stories 1

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. [X] (c) Rent equipment from Completely Unrelated Organization.

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

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

Rolling Hills Place
68 Beds / 60 Units
48,000 Square Feet

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: N/A
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	3 Acres	1979	$ 100,763	1
2					2
3	TOTALS			$ 100,763	3

Facility Name & ID Number Rolling Hills Manor # 0025239 Report Period Beginning: 11/1/19 Ending: 10/31/20

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					$	$ -		$ -	$	$	4
5	115		1979	1970	851,682	-	35	24,334	24,334	785,657	5
6			1992	1992	1,234,270	-	40	30,857	30,857	876,098	6
7			1992	1992	232,299	-	10	-		232,299	7
8			1998	1998	695,702	-	40	17,393	17,393	383,405	8
	Improvement Type**										
9	Various			1973	112,537	-	20	-			9
10	Various			1982	3,886	-	20	-		3,886	10
11	Various			1983	45,569	-	20	-		45,569	11
12	Various			1984	99,027	-	20	-		99,027	12
13	Various			1985	40,378	-	20	-		40,378	13
14	Various			1986	40,654	-	20	-		40,654	14
15	Various			1988	6,344	-	20	-			15
16	Various			1989	13,772	-	20	-		7,418	16
17	Various			1990	8,091	-	20	-		8,091	17
18	Various			1991	6,775	-	20	-		6,775	18
19	Various			1992	8,028	-	20	-		8,028	19
20	Various			1993	39,124	-	20	-		39,124	20
21	Various			1994	42,653	-	20	109	109	42,587	21
22	Various			1995	55,448	-	20	-		55,448	22
23	Various			1996	67,277	-	20	-		67,277	23
24	Various			1997	11,967	-	20	-		11,967	24
25	Various			1998	5,500	-	20	-		5,500	25
26	Various			1999	15,291	-	20	579	579	12,539	26
27	Various			2000	36,871	-	20	-		36,871	27
28	Various			2001	51,144	-	20	1,081	1,081	50,748	28
29	Various			2002	113,392	-	20	-		113,392	29
30	Various			2003	27,685	-	20	-		27,685	30
31	Various			2004	44,700	-	20	590	590	42,635	31
32	Various			2005	81,239	-	20	2,259	2,259	81,239	32
33	Various			2006	111,251	-	20	6,189	6,189	101,761	33
34	Various			2007	85,289	-	20	327	327	85,289	34
35	Various			2008	119,771	-	20	8,797	8,797	110,020	35
36	Various			2009	253,672	-	20	14,072		161,843	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 Rolling Hills Manor # 0025239 Report Period Beginning: 11/1/19 Ending: 10/31/20

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	2010	$ 135,235	$ -	20	$ 9,741	$ 9,741	$ 102,270	37
38	Various	2011	469,053	-	20	29,709	29,709	286,525	38
39	Various	2012	66,040	-	20	5,742	5,742	48,806	39
40	Various	2013	157,034	-	20	8,627	8,627	64,702	40
41	Various	2014	115,746	-	20	7,605	7,605	49,703	41
42				-		-			42
43	Fire Alarm	2015	2,609	-	20	174	174	868	43
44	Sewer Clean Out	2015	3,730	-	20	186	186	930	44
45	Flooring-Therapy Hallway	2015	4,950	-	20	330	330	1,650	45
46	Sewer Piping	2015	4,460	-	20	223	223	1,115	46
47	Roof Sofiting	2015	11,451	-	20	573	573	2,865	47
48	Door And Harware	2015	3,420	-	20	171	171	855	48
49	Rehab Room 484 Sq. Ft. Expansion New Construction	2015	156,648	-	20	3,916	3,916	19,580	49
50	Elevator Basin	2015	3,560	-	20	237	237	1,186	50
51	Roofing	2015	2,850	-	20	190	190	950	51
52	Dock Drainage Trench	2015	2,900	-	20	73	73	365	52
53	Roofing Unit Rtu#7	2015	4,949	-	20	247	247	1,235	53
54	Parkinglot Expansion	2015	19,212	-	20	960	960	4,800	54
55	Entry Concrete Replacement	2015	3,675	-	20	184	184	919	55
56	Tree	2015	680	-	20	23	23	114	56
57	Parkinglot Resealing	2015	7,856	-	20	524	524	2,183	57
58				-		-			58
59	Concreate Curbs	2016	8,710	-	20	436	436	1,962	59
60	Electrical Panels	2016	10,406	-	20	520	520	2,340	60
61	Activity Room Furniture	2016	2,750	-	20	138	138	621	61
62	Roofing	2016	1,400	-	20	140	140	630	62
63	Circuit Breakers	2016	2,922	-	20	146	146	657	63
64	Exhaust Fans	2016	4,438	-	20	296	296	1,332	64
65	Electrical System	2016	4,946	-	20	247	247	1,112	65
66	Electrical System	2016	2,614	-	20	131	131	589	66
67	Plumbing-Sewer Lines Under All 4 Wings	2016	14,387	-	20	719	719	3,236	67
68	Doors	2016	984	-	20	49	49	221	68
69				-		-			69
70	TOTAL (lines 4 thru 69)		$ 5,790,903	$		$ 178,843	$ 164,771	$ 4,187,531	70

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

Facility Name & ID Number Rolling Hills Manor # 0025239 Report Period Beginning: 11/1/19 Ending: 10/31/20

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	
1	Totals from Page 12A, Carried Forward		$ 5,790,903	$		$ 178,843	$ 178,843	$ 4,187,531	1
2	Roof Compressor	2016	3,714	-	20	371	371	1,670	2
3	Rtu #22	2016	3,302	-	20	330	330	1,485	3
4	Electrical System	2016	3,224	-	20	161	161	725	4
5	Doors And Frames	2017	776	-	20	19	19	76	5
6	Heating Units	2017	663	-	20	17	17	68	6
7	Faucets	2017	852	-	20	21	21	84	7
8	Elevator Seals	2017	3,590	-	20	90	90	360	8
9	Parking lot sealing	2017	4,510	-	20	150	150	600	9
10	Drain Well	2017	3,730	-	20	47	47	188	10
11	Sprinkler System Basement	2018	22,660	-	20	1,133	1,133	3,399	11
12	Rooftop Hvac Unit #12	2018	12,614	-	20	631	631	1,892	12
13	DON Flooring	2018	3,375	-	20	169	169	506	13
14	Parking Lot Sealant	2018	7,718	-	20	386	386	1,158	14
15	Roof-soffit resconstruction	2018	162,916	-	39	8,146	8,146	24,437	15
16	Roof removal and replacement of two areas of slope roof.	2019	5,000	-	39	128	128	192	16
17	Hot Water Mixing Valve	2019	6,230	-	20	312	312	468	17
18	Hot Water Heater	2019	6,734	-	10	673	673	1,010	18
19	Glass Hot Water tanks	2019	3,202	-	10	320	320	480	19
20	HVAC unitelectric cooling rooftop unit RTU-04	2019	12,938	-	10	1,294	1,294	1,941	20
21	HVAC unit rooftop unti #31	2019	12,117	-	10	1,212	1,212	1,818	21
22	Sealcoating	2020	5,238	-	5	524	524	524	22
23						-			23
24				-		-			24
25	Financial Statement Depreciation			253,574		-	(253,574)		25
26				-		-			26
27				-		-			27
28				-		-			28
29				-		-			29
30				-		-			30
31				-		-			31
32				-		-			32
33				-		-			33
34	TOTAL (lines 1 thru 33)		$ 6,076,006	$ 253,574		$ 194,976	$ (58,598)	$ 4,230,613	34

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

Facility Name & ID Number Rolling Hills Manor # 0025239 Report Period Beginning: 11/1/19 Ending: 10/31/20

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	$ 1,041,324	$	$ 78,676	$ 78,676	3-10	$ 675,040	71
72	Current Year Purchases	27,806		3,112	3,112	3-10	3,112	72
73	Fully Depreciated Assets	1,781,818				10	1,781,818	73
74								74
75	TOTALS	$ 2,850,948	$	$ 81,788	$ 81,788		$ 2,459,970	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	Facility	2010 Bus	2010	$ 23,846	$ -	$ 1,193	$ 1,193	5	$ 25,039	76
77					-	-				77
78					-	-				78
79					-	-				79
80	TOTALS			$ 23,846	$	$ 1,193	$ 1,193		$ 25,039	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)	$ 9,051,563	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 253,574	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 277,957	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 24,383	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,715,622	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	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	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 Rolling Hills Manor # 0025239 Report Period Beginning: 11/1/19 Ending: 10/31/20

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 ☐ 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 ☐ NO

16. Rental Amount for movable equipment: $ 153,502 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	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: **Rolling Hills Manor**
IDPH License ID Number: **0025239**
Fiscal Year End: **10/31/20**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Equipment Rental-Printers	101,931
Equipment Rental	51,571
Total - Line 16	**153,502**

Facility Name & ID Number Rolling Hills Manor # 0025239 Report Period Beginning: 11/1/19 Ending: 10/31/20

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

It is the policy of this facility to only hire certified nurses aides.

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	L39, C3	hrs	$	4,891	$ 352,179	$	4,891	$ 352,179	1
2	Licensed Speech and Language Development Therapist	L39, C3	hrs		554	39,919		554	39,919	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L39, C3	hrs		7,635	549,700		7,635	549,700	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				226,657		226,657	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	L39, C2&3			2	140	28,193	2	28,333	12
13	Other (specify):									13
14	TOTAL			$	13,082	$ 941,938	$ 254,850	13,082	$ 1,196,788	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.

STATE OF ILLINOIS

Facility Name & ID Number Rolling Hills Manor # 0025239 Report Period Beginning: 11/1/19 Ending: 10/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 10/31/20 (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	$ 2,091,367	$ 2,091,367	1
2	Cash-Patient Deposits	-	-	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 250,000)	2,078,554	2,078,554	3
4	Supply Inventory (priced at)	315,896	315,896	4
5	Short-Term Investments	-	-	5
6	Prepaid Insurance	69,007	69,007	6
7	Other Prepaid Expenses	21,232	21,232	7
8	Accounts Receivable (owners or related parties)	-	-	8
9	Other(specify): See Sch 17A	32,112	32,112	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,608,168	$ 4,608,168	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	-	-	11
12	Long-Term Investments	-	-	12
13	Land	100,763	100,763	13
14	Buildings, at Historical Cost	6,590,345	5,404,196	14
15	Leasehold Improvements, at Historical Cost	671,810	671,810	15
16	Equipment, at Historical Cost	2,877,851	2,874,794	16
17	Accumulated Depreciation (book methods)	(7,658,005)	(6,715,622)	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 (spe	-	-	22
23	Other(specify): See Sch 17A	97,866	97,866	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,680,630	$ 2,433,807	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,288,798	$ 7,041,975	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 536,740	$ 536,740	26
27	Officer's Accounts Payable	-	-	27
28	Accounts Payable-Patient Deposits	-	-	28
29	Short-Term Notes Payable	1,881,300	1,881,300	29
30	Accrued Salaries Payable	599,717	599,717	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,348	5,348	31
32	Accrued Real Estate Taxes(Sch.IX-B)	-	-	32
33	Accrued Interest Payable	3,170	3,170	33
34	Deferred Compensation	7,901	7,901	34
35	Federal and State Income Taxes	-	-	35
	Other Current Liabilities(specify):			
36	See Sch 17A	9,603	9,603	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,043,779	$ 3,043,779	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,250,000	1,250,000	39
40	Mortgage Payable	-	-	40
41	Bonds Payable	1,583,780	1,583,780	41
42	Deferred Compensation	-	-	42
	Other Long-Term Liabilities(specify):			
43	Other Long Term Liab, See Sch 17A	332,368	332,368	43
44		-	-	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,166,148	$ 3,166,148	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,209,927	$ 6,209,927	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,078,871	$ 832,048	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,288,798	$ 7,041,975	48

*(See instructions.)

Facility Name: **Rolling Hills Manor**
IDPH License ID Number: **0025239**
Fiscal Year End: **10/31/20**

Schedule 17A

XV. Balance Sheet
Line 9 Current Assets Other (specify):

Account No.	Description	Operating	After Consolidation
102600	#NAME?	#NAME?	#NAME?
122100	#NAME?	#NAME?	#NAME?
	Total - Line 9	**#NAME?**	**#NAME?**
		#NAME?	**#NAME?**

XV. Balance Sheet
Line 23 Long-Term Assets Other (specify):

	Description	Operating	After Consolidation
120500	#NAME?	#NAME?	#NAME?
120600	#NAME?	#NAME?	#NAME?
120700	#NAME?	#NAME?	#NAME?
120800	#NAME?	#NAME?	#NAME?
	Total - Line 23	**#NAME?**	**#NAME?**
		#NAME?	#NAME?

XV. Balance Sheet
Line 36 Other Current Liabilities (specify):

	Description	Operating	After Consolidation
230501	#NAME?	#NAME?	#NAME?
236100	#NAME?	#NAME?	#NAME?
250100	#NAME?	#NAME?	#NAME?
250400	#NAME?	#NAME?	#NAME?
261000	#NAME?	#NAME?	#NAME?
262000	#NAME?	#NAME?	#NAME?
	Total - Line 36	**#NAME?**	**#NAME?**
		#NAME?	#NAME?

XV. Balance Sheet
Line 43 Other Long Term Liabilities (specify):

	Description	Operating	After Consolidation
280600	#NAME?	#NAME?	#NAME?
	Total - Line 36	**#NAME?**	**#NAME?**
		#NAME?	#NAME?

Facility Name & ID Number Rolling Hills Manor # 0025239 Report Period Beginning: 11/1/19 Ending: 10/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,365,528	1
2	Restatements (describe):		2
3			3
4	Prior period adjustment	323,912	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,689,440	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(610,569)	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)**	$ (610,569)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,078,871	24 *

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

Facility Name & ID Number Rolling Hills Manor # 0025239 Report Period Beginning: 11/1/19 Ending: 10/31/20

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	$ 9,851,184	1
2	Discounts and Allowances for all Levels	(1,867,417)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,983,767	3
	B. Ancillary Revenue		
4	Day Care	-	4
5	Other Care for Outpatients	-	5
6	Therapy	1,749,833	6
7	Oxygen	59,514	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,809,347	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	448	13
14	Non-Patient Meals	3,063	14
15	Telephone, Television and Radio	-	15
16	Rental of Facility Space	-	16
17	Sale of Drugs	367,928	17
18	Sale of Supplies to Non-Patients	24,892	18
19	Laboratory	110,021	19
20	Radiology and X-Ray	26,176	20
21	Other Medical Services	-	21
22	Laundry	-	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 532,528	23
	D. Non-Operating Revenue		
24	Contributions	1,742	24
25	Interest and Other Investment Income***	2,669	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,411	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Sch 19A	710,194	28
28a		-	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 710,194	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,040,247	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,960,390	31
32	Health Care	4,996,229	32
33	General Administration	2,470,349	33
	B. Capital Expense		
34	Ownership	509,351	34
	C. Ancillary Expense		
35	Special Cost Centers	1,496,519	35
36	Provider Participation Fee	217,978	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,650,816	40
41	**Income before Income Taxes (line 30 minus line 40)****	(610,569)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (610,569)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,911,496	44
45	Private Pay - Net Inpatient Revenue	3,312,230	45
46	Medicare - Net Inpatient Revenue	1,721,869	46
47	Other-(specify)		47
48	Other-(specify) Medicare Advantage	38,172	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,983,767	49

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

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

^Entity is a cash basis taxpayer.

Facility Name: **Rolling Hills Manor**
IDPH License ID Number: **0025239**
Fiscal Year End: **10/31/20**

Schedule 19A

XVII. Income Statement
Line 28 Other Revenue (specify):

	Description	Amount
303700	#NAME?	#NAME?
304200	#NAME?	#NAME?
304300	#NAME?	#NAME?
334300	COVID Funding	#NAME?
337100	#NAME?	#NAME?
	Total - Line 28	**#NAME?**
		#NAME?

Facility Name & ID Number Rolling Hills Manor # 0025239 Report Period Beginning: 11/1/19 Ending: 10/31/20

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	1,960	2,320	$ 86,429	$ 37.25	1
2	Assistant Director of Nursing	1,100	1,354	63,939	47.22	2
3	Registered Nurses	31,876	35,158	1,332,146	37.89	3
4	Licensed Practical Nurses	20,336	23,254	733,288	31.53	4
5	CNAs & Orderlies	80,889	90,125	1,624,179	18.02	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,310	9,435	164,156	17.40	8
9	Activity Director	2,012	2,213	45,105	20.38	9
10	Activity Assistants	3,519	3,887	47,788	12.29	10
11	Social Service Workers	3,889	4,379	102,898	23.50	11
12	Dietician					12
13	Food Service Supervisor	972	1,136	33,943	29.88	13
14	Head Cook	9,959	10,904	207,268	19.01	14
15	Cook Helpers/Assistants	14,858	16,228	199,036	12.26	15
16	Dishwashers					16
17	Maintenance Workers	11,485	13,127	232,013	17.67	17
18	Housekeepers	24,659	27,226	322,816	11.86	18
19	Laundry	14,662	16,696	210,797	12.63	19
20	Administrator	604	831	70,744	85.13	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,175	1,375	39,415	28.67	23
24	Clerical	22,530	25,211	508,066	20.15	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,619	2,046	81,124	39.65	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,575	3,952	74,538	18.86	31
32	Other Health C: MDS Coordinator	1,705	2,272	89,789	39.52	32
33	Other(specify) Admissions Direct	2,042	2,320	65,026	28.03	33
34	TOTAL (lines 1 - 33)	263,736	295,449	$ 6,334,503 *	$ 21.44	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	Monthly	$ 39,764	L1, C3	35
36	Medical Director	Monthly	24,000	L9, C3	36
37	Medical Records Consultant	Monthly	400	L10, C3	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	Monthly	7,062	L11, C3	44
45	Social Service Consultant				45
46	Other(specify) Rehab Consultant	Monthly	3,000	L10A, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 74,226		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	1,511	87,727	L10, C3	51
52	Certified Nurse Assistants/Aides	4,531	120,579	L10, C3	52
53	TOTAL (lines 50 - 52)	6,042	$ 208,306		53

Facility Name & ID Number Rolling Hills Manor # 0025239 Report Period Beginning: 11/1/19 Ending: 10/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Scott Myers	Administrator	0	$ 70,744
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 70,744

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
See Schedule 21C		$ 232,369
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 232,369

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 125,234
Unemployment Compensation Insurance	8,989
FICA Taxes	377,501
Employee Health Insurance	536,539
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	3,599
Physicals & TB Expense	12,927
Life Insurance	16,737
Flex Plan Insurance	(3,523)
401K	(2,160)
Other Employee Benefits	25,479
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,101,322

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	27,489
Health Care Worker Background Check	
(Indicate # of checks performed 886)	10,635
Miscellaneous Licenses & Fees	5,767
Miscellaneous Dues & Subscriptions	1,989
IHCA Dues	7,533
Memberships	11,966
Less: Public Relations Expense	(2,077)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 67,282

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	14
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14

**See instructions.

Facility Name: **Rolling Hills Manor**
IDPH License ID Number: **0025239**
Fiscal Year End: **10/31/20**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
ADP	Payroll Services	41,778
Polsinelli	Legal	43,812
Smith Amundsen	Legal	578
Axcell Technologies	IT Support	28,568
Cardmember Services	IT Support	631
AT&T U	IT Support	585
AmericanEagle.co	IT Support	2,700
HealthStream, Inc	IT Support	1,925
To record monthly prepaid expense	IT Support	29,600
Ability Network, Inc	IT Support	10,175
Switchfast Technologies	IT Support	5,222
James Stefo Jr.	Accounting	18,200
Marcum (Frost Ruttenberg)	Accounting	20,235
RSM LLP	Accounting	28,360
Total (agree to Schedule V, line 19, column 3)		232,369
Non-allowable Legal	Legal Fees	(14,852)
Total (agree to Schedule V, line 19, column 8)		217,517

Facility Name & ID Number Rolling Hills Manor # 0025239 Report Period Beginning: 11/1/19 Ending: 10/31/20

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $7,533 ; AANAC $131**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(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? **3-10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **80,968** Line **10**

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

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

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

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **217,978**
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. $ **3,063**

(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 1**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained**
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? **N/A**
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: **RSM US LLP**

(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.