

		FOR BHF USE					

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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: <u>0030312</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Hillcrest Retirement Village</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/16</u> to <u>12/31/16</u> 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.																							
Address: <u>1740 N Circuit Drive</u> <u>Round Lake Beach</u> <u>60073</u>																									
Number City Zip Code																									
County: <u>Lake</u>																									
Telephone Number: <u>(847) 546-5301</u> Fax # <u>(847) 546-7563</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____ *</td></tr><tr><td rowspan="4">Paid Preparer</td><td>* Subject to the attached Accountants Consulting Report (Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td></tr><tr><td>(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____ *	Paid Preparer	* Subject to the attached Accountants Consulting Report (Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>												
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	(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>																								
Date of Initial License for Current Owners: <u>11/29/1985</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☒ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☒ "Sub-S" Corp.	_____		☐ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☐ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		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																							
Name: <u>Steven N. Lavenda</u> Telephone Number: <u>(847) 282-6300</u>																									
Email Address: _____																									

Facility Name & ID Number Hillcrest Retirement Village

0030312 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	57	Skilled (SNF)	57	20,862
2		Skilled Pediatric (SNF/PED)		
3	87	Intermediate (ICF)	87	31,842
4		Intermediate/DD		
5		Sheltered Care (SC)		
6		ICF/DD 16 or Less		
7	144	TOTALS	144	52,704

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	4,235	6,549	10,784	8
9	SNF/PED				9
10	ICF	33,380		33,380	10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	33,380	4,235	6,549	44,164

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.80%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

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

☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

☐

NO

☒

I. On what date did you start providing long term care at this location?

Date started 11/29/1985

J. Was the facility purchased or leased after January 1, 1978?

YES

☒

Date 11/29/1985

NO

☐

K. Was the facility certified for Medicare during the reporting year?

YES

☒

NO

☐

If YES, enter number

of beds certified

41

and days of care provided

3,174

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL

☒

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

☒

NO

☐

Tax Year: 12/31/2016

Fiscal Year: 12/31/2016

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

Facility Name & ID Number Hillcrest Retirement Village # 0030312 Report Period Beginning: 01/01/16 Ending: 12/31/16
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	344,589	39,438	8,136	392,163		392,163		392,163			1
2	Food Purchase		274,781		274,781	(30,305)	244,476	(263)	244,213			2
3	Housekeeping	235,070	18,450		253,520		253,520		253,520			3
4	Laundry	125,075	9,637		134,712		134,712		134,712			4
5	Heat and Other Utilities			106,679	106,679		106,679	(1,980)	104,699			5
6	Maintenance	43,626	18,483	166,485	228,594		228,594	(15,527)	213,067			6
7	Other (specify):*											7
8	TOTAL General Services	748,360	360,789	281,300	1,390,449	(30,305)	1,360,144	(17,770)	1,342,374			8
	B. Health Care and Programs											
9	Medical Director			33,729	33,729		33,729		33,729			9
10	Nursing and Medical Records	2,383,183	281,210	19,452	2,683,845		2,683,845		2,683,845			10
10a	Therapy	228,397			228,397		228,397		228,397			10a
11	Activities	171,431	7,267		178,698		178,698		178,698			11
12	Social Services	172,861			172,861		172,861		172,861			12
13	CNA Training											13
14	Program Transportation			1,450	1,450		1,450		1,450			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,955,872	288,477	54,631	3,298,980		3,298,980		3,298,980			16
	C. General Administration											
17	Administrative	216,678		554,552	771,230		771,230	(437,885)	333,345			17
18	Directors Fees											18
19	Professional Services			155,182	155,182		155,182	(2,112)	153,070			19
20	Dues, Fees, Subscriptions & Promotions			128,339	128,339		128,339	(103,488)	24,851			20
21	Clerical & General Office Expenses	199,096	948	215,246	415,290		415,290	(130,279)	285,011			21
22	Employee Benefits & Payroll Taxes			699,578	699,578	30,305	729,883	(27,096)	702,787			22
23	Inservice Training & Education											23
24	Travel and Seminar			37,862	37,862		37,862	(25,904)	11,958			24
25	Other Admin. Staff Transportation			1,741	1,741		1,741		1,741			25
26	Insurance-Prop.Liab.Malpractice			120,536	120,536		120,536	14,001	134,537			26
27	Other (specify):*							19,412	19,412			27
28	TOTAL General Administration	415,774	948	1,913,036	2,329,758	30,305	2,360,063	(693,350)	1,666,713			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,120,006	650,214	2,248,967	7,019,187		7,019,187	(711,121)	6,308,066			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.

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			72,855	72,855		72,855	80,882	153,737			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,931	5,931		5,931	215,137	221,068			32
33	Real Estate Taxes							109,290	109,290			33
34	Rent-Facility & Grounds			552,000	552,000		552,000	(534,275)	17,725			34
35	Rent-Equipment & Vehicles			10,864	10,864		10,864	618	11,482			35
36	Other (specify):*							36,085	36,085			36
37	TOTAL Ownership			641,650	641,650		641,650	(92,263)	549,387			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		147,257	370,322	517,579		517,579		517,579			39
40	Barber and Beauty Shops	9,554			9,554		9,554		9,554			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			326,541	326,541		326,541		326,541			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	9,554	147,257	696,863	853,674		853,674		853,674			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	4,129,560	797,471	3,587,480	8,514,511		8,514,511	(803,384)	7,711,127			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(2,436)	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	(13,952)	30		9
10	Interest and Other Investment Income	(4,129)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(263)	02		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	(2,062)	20		20
21	Owner or Key-Man Insurance	(5,096)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(66,794)	21		24
25	Fund Raising, Advertising and Promotional	(96,536)	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	(145,088)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (336,356)		\$	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)	(467,028)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (467,028)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (803,384)		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

ID#

0030312

Report Period Beginning:

01/01/16

Ending:

12/31/16

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Misc. Income	\$ (10,163)	21	1
2	Bank Charges	(21,741)	21	2
3	Non-Allowable Telephone	(10,827)	21	3
4	Non-Allowable Expense	(5,475)	21	4
5	PAC Dues	(4,890)	20	5
6	Amortization - Bldg. Co	(6,371)	36	6
7	Accounting Fees - Bldg. Co	(23,367)	19	7
8	Additional R&M	1,947	06	8
9	Non-allowable Legal	(2,112)	19	9
10	Out-of State Seminars	(25,904)	24	10
11	Non-allowable Expense	(18,711)	21	11
12	Capitalized R&M	(17,474)	06	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	(145,088)		49

ID#

0030312

Report Period Beginning:

01/01/16

Ending:

12/31/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hillcrest Retirement Village # 0030312 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(263)											(263)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(2,436)		456									(1,980)	5
6	Maintenance	(15,527)											(15,527)	6
7	Other (specify):*													7
8	TOTAL General Services	(18,226)		456									(17,770)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs													16
	C. General Administration													
17	Administrative			(33,000)	(141,000)	(116,833)	(147,052)						(437,885)	17
18	Directors Fees													18
19	Professional Services	(25,479)	23,367										(2,112)	19
20	Fees, Subscriptions & Promotions	(103,488)											(103,488)	20
21	Clerical & General Office Expenses	(133,711)		3,432									(130,279)	21
22	Employee Benefits & Payroll Taxes	(5,096)		(22,000)									(27,096)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(25,904)											(25,904)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice		13,768	233									14,001	26
27	Other (specify):*			7,200	5,214	6,998							19,412	27
28	TOTAL General Administration	(293,677)	37,135	(44,135)	(135,786)	(109,835)	(147,052)						(693,350)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(311,904)	37,135	(43,679)	(135,786)	(109,835)	(147,052)						(711,121)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Hillcrest Retirement Village # 0030312 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(13,952)	94,810	24									80,882	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(4,129)	219,263		3								215,137	32
33	Real Estate Taxes		109,290										109,290	33
34	Rent-Facility & Grounds		(552,000)	17,725									(534,275)	34
35	Rent-Equipment & Vehicles			618									618	35
36	Other (specify):*	(6,371)	42,456										36,085	36
37	TOTAL Ownership	(24,452)	(86,181)	18,367	3								(92,263)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(336,356)	(49,046)	(25,312)	(135,783)	(109,835)	(147,052)						(803,384)	45

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 6-Supplemental		See 6-Supplemental		See 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

☐ 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	\$ 552,000	Hillcrest Development, LLC		\$	(552,000)	1
2	V	36	Amortization		Hillcrest Development, LLC		6,371	6,371	2
3	V	33	Real Estate Taxes - Lots		Hillcrest Development, LLC		11,936	11,936	3
4	V	33	Real Estate Taxes		Hillcrest Development, LLC		97,354	97,354	4
5	V	19	Accounting Fees		Hillcrest Development, LLC		23,367	23,367	5
6	V	36	MIP Expense		Hillcrest Development, LLC		36,085	36,085	6
7	V	30	Depreciation		Hillcrest Development, LLC		94,810	94,810	7
8	V	32	Interest Expense	288	Hillcrest Development, LLC		219,551	219,263	8
9	V	26	Insurance		Hillcrest Development, LLC		13,768	13,768	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 552,288			\$ 503,242	\$ * (49,046)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	A.H.B. D/B/A ABH MANAGEMENT	100.00%	\$ 456	\$ 456	15
16	V	21	CLERICAL AND GENERAL		A.H.B. D/B/A ABH MANAGEMENT	100.00%	3,432	3,432	16
17	V	26	INSURANCE		A.H.B. D/B/A ABH MANAGEMENT	100.00%	233	233	17
18	V	30	DEPRECIATION		A.H.B. D/B/A ABH MANAGEMENT	100.00%	24	24	18
19	V	34	RENT		A.H.B. D/B/A ABH MANAGEMENT	100.00%	17,725	17,725	19
20	V	35	EQUIPMENT RENT		A.H.B. D/B/A ABH MANAGEMENT	100.00%	618	618	20
21	V	27	EMP. BEN.-DIRECT ALLOC.		A.H.B. D/B/A ABH MANAGEMENT	100.00%	7,200	7,200	21
22	V								22
23	V	17	HOME OFFICE	33,000	A.H.B. D/B/A ABH MANAGEMENT	100.00%		(33,000)	23
24	V	22	HOME OFFICE BENEFITS	22,000	A.H.B. D/B/A ABH MANAGEMENT	100.00%		(22,000)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 55,000			\$ 29,688	\$ * (25,312)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMIN. - KARLA BISHOP	\$	KARLA BISHOP, INC.	100.00%	\$ 50,000	\$ 50,000	15
16	V	27	EMPLOYEE BENEFITS		KARLA BISHOP, INC.	100.00%	5,214	5,214	16
17	V	32	INTEREST EXPENSE		KARLA BISHOP, INC.	100.00%	3	3	17
18	V								18
19	V	17	MANAGEMENT FEES	191,000	KARLA BISHOP, INC.	100.00%		(191,000)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 191,000			\$ 55,217	\$ * (135,783)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMIN. - E. ROSENBAUM	\$	HEALTH RESOURCE, INC.	100.00%	\$ 66,667	\$ 66,667	15
16	V	27	EMPLOYEE BENEFITS		HEALTH RESOURCE, INC.	100.00%	6,998	6,998	16
17	V								17
18	V								18
19	V	17	MANAGEMENT FEES	183,500	HEALTH RESOURCE, INC.	100.00%		(183,500)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 183,500			\$ 73,665	\$ * (109,835)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management Fee- K. Bishop	\$	Hillcrest Consulting LLC	100.00%	\$ 191,000	\$ 191,000	15
16	V	17	Management Fee- Health Resource		Hillcrest Consulting LLC	100.00%	183,500	183,500	16
17	V								17
18	V	17	Management Fee	521,552	Hillcrest Consulting LLC	100.00%		(521,552)	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 521,552			\$ 374,500	\$ * (147,052)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

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	JACK AND KARLA BISHOP	32.500%	ABBOTT HOUSE LLC	HIGHLAND PARK	HILLCREST DEVELOPMENT, LLC		BUILDING CO.	1
2	EARL ROSENBAUM TRUSTEE	33.750%	BAYSIDE TERRACE LLC	WAUKEGAN	KARLA BISHOP, INC.	LAKE BLUFF	MANAGEMENT CO.	2
3	MARVIN FOX	4.042%			A.H.B. D/B/A ABH MANAGEMEN	HIGHLAND PARK	HOME OFFICE	3
4	ROBERT A. ROSE LIVING TRUST	4.042%			HEALTH RESOURCE, INC.	HIGHLAND PARK	MANAGEMENT CO.	4
5	RICHARD S. SGARLATA	2.526%			HILLCREST CONSULTING, LLC	ROUND LAKE BEACH	CONSULTING CO.	5
6	NOSHIR DARUWALLA	2.526%						6
7	ARTHUR ROTHBLATT	2.526%						7
8	LAWRENCE SAVITT REVOCABLE TRUST	4.000%						8
9	JUDY ROSENBAUM	2.500%						9
10	ILA ROSENBAUM	0.313%						10
11	RALPH ROSENBAUM	0.313%						11
12	MITCHELL ROSENBAUM	0.313%						12
13	PAUL ROSENBAUM	0.313%						13
14	GAIL GOODSITE REVOCABLE TRUST	3.405%						14
15	EDWARD G ROTHBLATT ADMIN TRUST	4.042%						15
16	BETTE COHEN	1.891%						16
17	ALAN ROSENBAUM FAMILY TRUST	0.500%						17
18	IVY FISHMAN FAMILY TRUST	0.500%						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

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								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								25
26								26
27								27
28								28
29								29
30								30

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	Alan Rosenbaum	Administrator	Administrative	0.00%	See Attached	50	100.00%	Salary	\$ 216,678	17-1,17-7	1	
2	Karla Bishop	President	Administrative	32.50%	See Attached	10	25.00%	Alloc-Admin	50,000	17 - 7	2	
3	Earl Rosenbaum	Vice President	Administrative	33.75%	See Attached	15	33.33%	Alloc-Admin	66,667	17 - 7	3	
4											4	
5											5	
6											6	
7											7	
8											8	
9											9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12	
13								TOTAL	\$ 333,345		13	

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

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

Facility Name & ID Number Hillcrest Retirement Village # 0030312 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Hillcrest Retirement Village # 0030312 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

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

Name of Related Organization A.H.B. D/B/A ABH MANAGEMENT
Street Address 600 CENTRAL AVENEUE
City / State / Zip Code HIGHLAND PARK, IL 60035
Phone Number (847)432-7262
Fax Number (847)432-6095

	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	5	UTILITIES	PATIENT DAYS	134,536	3	\$ 1,390	\$ 44,164	\$ 456	1
	2	21	CLERICAL AND GENERAL	PATIENT DAYS	134,536	3	10,455	44,164	3,432	2
	3	26	INSURANCE	PATIENT DAYS	134,536	3	710	44,164	233	3
	4	30	DEPRECIATION	PATIENT DAYS	134,536	3	72	44,164	24	4
	5	34	RENT	PATIENT DAYS	134,536	3	53,997	44,164	17,725	5
	6	35	EQUIPMENT RENT	PATIENT DAYS	134,536	3	1,882	44,164	618	6
	7									7
	8	17	ADM. COMP.- IVY FISHMAN	AVG. HOURS WORKED	40	1	17,500			8
	9	27	EMP. BEN.-DIRECT ALLOC.	DIRECT		1	7,200		7,200	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				\$ 93,206	\$		\$ 29,688	25

Facility Name & ID Number Hillcrest Retirement Village # 0030312 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization KARLA BISHOP, INC.
Street Address 271 RIVERS DRIVE
City / State / Zip Code LAKE BLUFF, IL. 60044
Phone Number (847)432-7262
Fax Number (847)432-6095

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	ADMIN. - KARLA BISHOP	AVG. HOURS WORKED	40	3	\$ 200,000	\$ 200,000	10	\$ 50,000	1
2	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	40	3	20,856		10	5,214	2
3	32	INTEREST EXPENSE	AVG. HOURS WORKED	40	3			10	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					\$ 220,856	\$ 200,000		\$ 55,217	25

Facility Name & ID Number Hillcrest Retirement Village # 0030312 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization HEALTH RESOURCE, INC.
Street Address P.O. BOX 1275
City / State / Zip Code HIGHLAND PARK, IL. 60035
Phone Number (847)432-7262
Fax Number (847)432-6095

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	ADMIN. - E. ROSENBAUM	AVG. HOURS WORKED	45	3	\$ 200,000	\$ 200,000	15	\$ 66,667	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	45	3			15		2
3	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	45	3	20,995		15	6,998	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					\$ 220,995	\$ 200,000		\$ 73,665	25

Facility Name & ID Number Hillcrest Retirement Village # 0030312 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Hillcrest Consulting LLC
Street Address 1740 N. Circuit Drive
City / State / Zip Code Round Lake Beach, IL 60073
Phone Number (847) 432-7262
Fax Number ()

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	17	Management Fee- K. Bishop				\$	\$		\$ 191,000	1
2	17	Management Fee- Health Resource							183,500	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					\$	\$		\$ 374,500	25

Facility Name & ID Number Hillcrest Retirement Village # 0030312 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Hillcrest Retirement Village # 0030312 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Hillcrest Retirement Village # 0030312 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Hillcrest Retirement Village # 0030312 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office
or parent organization costs? (See instructions.) YES ☐ NO ☐

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Hillcrest Retirement Village # 0030312 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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

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	HUD		X	Mortgage			\$	5,521,571			\$	219,551	1
2													2
3													3
4													4
5					-								5
	Working Capital												
6	American National Bank		X	Line of Credit				320,000				2,142	6
7	Raymond Chevrolet		X	Auto Loan				29,326				3,789	7
8	See Supplemental Schedule				-			75,464					8
9	TOTAL Facility Related						\$	5,946,361			\$	225,481	9
	B. Non-Facility Related*												
10	Interest Income		X									(4,129)	10
11	Hilcrest Development LLC		X									(288)	11
12	Allocated from Karla Bishop		X									3	12
13					-								13
14	TOTAL Non-Facility Related						\$				\$	(4,414)	14
15	TOTALS (line 9+line14)						\$	5,946,361			\$	221,068	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 36,085 Line # 36

* 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.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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													2
3													3
4													4
5													5
6													6
7	TOTAL Long-Term												7
	Working Capital												
8	Van Caravan		X	Auto Loan			\$		\$ 35,010			\$	8
9	Dodge Durango		X	Auto Loan					40,455				9
10													10
11													11
12													12
13													13
14	TOTAL Working Capital								75,464				14
	B. Non-Facility Related*												
15							\$		\$			\$	15
16													16
17													17
18													18
19													19
20	TOTAL Non-Facility Related												20

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

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

B. 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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Hillcrest Retirement Village

COUNTY

Lake

FACILITY IDPH LICENSE NUMBER

0030312

CONTACT PERSON REGARDING THIS REPORT

Steve Lavenda

TELEPHONE

(847) 236-6300

FAX #:

(847) 236-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1. <u>06-17-200-009</u>	<u>Long Term Care Property</u>	\$ <u>2,989.21</u>	\$ <u>2,989.21</u>
2. <u>06-17-200-010</u>	<u>Long Term Care Property</u>	\$ <u>80,346.88</u>	\$ <u>80,346.88</u>
3. <u>06-17-200-011</u>	<u>Long Term Care Property</u>	\$ <u>1,517.53</u>	\$ <u>1,517.53</u>
4. <u>06-17-214-011</u>	<u>Parking Lot</u>	\$ <u>5,118.04</u>	\$ <u>5,118.04</u>
5. <u>06-17-214-010</u>	<u>Parking Lot</u>	\$ <u>5,118.04</u>	\$ <u>5,118.04</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>95,089.70</u>	\$ <u>95,089.70</u>

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 a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

FACILITY NAME Hillcrest Retirement Village COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0030312

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

Enter the tax index number and real estate tax assessed for 2015 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 2015.

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?

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.)

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,277

B. General Construction Type: Exterior BrickFrameNumber of Stories 1

C. Does the Operating Entity?

☐ (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?

☒ (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).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES☒ 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		1985	\$ 57,500	1
2	Parking Lot		1985	132,513	2
3	TOTALS			\$ 190,013	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	144		1985	1976	\$ 1,430,000	\$	30	\$	\$	\$ 1,430,000	4
5			1989	1989	780,798	24,787	31.6	24,709	(78)	677,857	5
6			1994	1994	554,167	20,152	39	14,209	(5,943)	297,776	6
7											7
8											8
	Improvement Type**										
9	Various		1987		9,045		20			9,045	9
10	Various		1989		36,275		20			36,265	10
11	Various		1990		2,002		20			2,000	11
12	Various		1991		16,248		20			15,533	12
13	Various		1992		8,821		20			8,821	13
14	Various		1993		3,000		20			3,000	14
15	Various		1994		51,668		20			51,668	15
16	Various		1995		8,799		20	116	116	6,691	16
17	Various		1996		51,722		20	1,461	1,461	51,719	17
18	Various		1997		4,495		20	223	223	4,437	18
19	Various		1998		24,327		20	1,216	1,216	22,660	19
20	Various		1999		9,947		20	497	497	8,702	20
21	Various		2000		7,062		20	353	353	5,651	21
22	Various		2001		32,994		20	1,194	1,194	18,318	22
23	Various		2002		6,950		20	93	93	6,950	23
24	Various		2003		10,904		20	440	440	8,096	24
25	Various		2004		8,143		20	367	367	5,464	25
26	Various		2005		7,695		20	202	202	5,956	26
27	Various		2006		30,616		20	739	739	23,523	27
28	Various		2007		10,035		20	1,004	1,004	9,701	28
29	Various		2009		8,713		20	588	588	4,408	29
30	Various		2010		34,981		20	2,548	2,548	17,203	30
31	Various		2011		32,168		20	3,403	3,403	19,903	31
32											32
33											33
34											34
35											35
36											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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
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								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67	Related Building Company (Pages 12F & 12G)	429,228			18,790	18,790	84,841	67
68	Related Party Allocations (Pages 12H & 12I)	2,963	24		66	42	2,580	68
69	Financial Statement Depreciation		122,726			(122,726)		69
70	TOTAL (lines 4 thru 69)	\$ 3,613,766	\$ 167,689		\$ 72,218	\$ (95,471)	\$ 2,838,768	70

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

Facility Name & ID Number Hillcrest Retirement Village

0030312

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,613,766	\$ 167,689		\$ 72,218	\$ (95,471)	\$ 2,838,768	1
2	Parking Lot	2013	345,665		20	23,044	23,044	92,177	2
3	Parking Lot Sealcoating	2013	2,770		20	139	139	485	3
4	Air Conditioner	2014	6,031		20	1,206	1,206	3,619	4
5	Air Conditioners	2014	2,556		20	511	511	1,108	5
6	Door Knobs	2014	12,452		20	1,245	1,245	2,698	6
7	Insulation	2014	14,000		20	1,400	1,400	3,033	7
8	Faucets	2014	21,411		20	2,141	2,141	4,639	8
9	Air Conditioners	2014	2,538		20	127	127	328	9
10	Sidewalk	2014	12,225		20	611	611	1,528	10
11	Door & Frame	2014	3,680		20	184	184	445	11
12	Air Condition	2015	2,807		20	140	140	257	12
13	Roof - Aloha Const.	2015	5,000		20	250	250	375	13
14	Seal Coating & Restriping	2015	2,800		20	140	140	210	14
15	Electrical Upgrade	2015	3,325		20	166	166	305	15
16	Bookkeeping Room Remodel- Floors, Drywall, Carpentry Work	2015	3,500		20	175	175	350	16
17	Electrical Work For Offices & Resident Rooms	2015	2,825		20	141	141	271	17
18	Accesible Automatic Door Operator	2015	6,226		20	311	311	311	18
19	Fastbond 30 Contact Cement	2016	3,659		20	183	183	183	19
20	Demo Offices,Pipe For Electric, Drywall & Taping	2016	5,145		20	236	236	236	20
21	Install New Doors And Cabinets In Offices	2016	7,368		20	307	307	307	21
22	Wallcovering In Hallways	2016	3,409		20	142	142	142	22
23	Drywall In Dining Area	2016	8,208		20	274	274	274	23
24	Doors In Dining Area	2016	2,590		20	76	76	76	24
25	Wall Board Trim - Hallways	2016	3,240		20	81	81	81	25
26	Travertine Tile - Rooms 500, 501 And 502	2016	5,233		20	131	131	131	26
27	Kitchen Hood Fans	2016	4,790		20	40	40	40	27
28	Flooring - Rooms 503 And 504	2016	3,405		20	28	28	28	28
29	Generator Repairs	2016	3,564		20	178	178	178	29
30	Demo And Rough In Electrical For Future Dining/Kitchen Area	2016	3,315		20	166	166	166	30
31	Repaving Parking Lot	2016	10,595		20	530	530	530	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,128,098	\$ 167,689		\$ 106,522	\$ (61,167)	\$ 2,953,277	34

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$4,128,098	\$167,689		\$106,522	\$ (61,167)	\$2,953,277	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$4,128,098	\$167,689		\$106,522	\$ (61,167)	\$2,953,277	34

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

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 12C, Carried Forward		\$ 4,128,098	\$ 167,689		\$ 106,522	\$ (61,167)	\$ 2,953,277	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
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,128,098	\$ 167,689		\$ 106,522	\$ (61,167)	\$ 2,953,277	34

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

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 12D, Carried Forward		\$ 4,128,098	\$ 167,689		\$ 106,522	\$ (61,167)	\$ 2,953,277	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
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17									17
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,128,098	\$ 167,689		\$ 106,522	\$ (61,167)	\$ 2,953,277	34

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

Facility Name & ID Number Hillcrest Retirement Village

0030312

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Hillcrest Development	1993	53,433		20			53,433	9
10	Water Heater	2015	5,800		20	290	290	580	10
11	Retention Pond	2015	30,590		20	1,530	1,530	3,059	11
12	Flooring, Hand/Crash Rails, Drywall Doors/Carpentry -	2015	22,000		20	1,100	1,100	2,200	12
13	100-500 wings/ Nurse stations 1 & 3, bathrooms								13
14	Pipe wire/Install electrical in courtyard/nurse's station 1 & 3	2015	11,157		20	558	558	1,116	14
15	Corner Guards/Handrails, Wallcovering-100-500 wings/corridors	2015	26,582		20	1,329	1,329	2,658	15
16	Wander Protection System	2015	6,203		20	310	310	620	16
17	Flooring: Hallways, Reception, Dining, Exercise Room, Offices	2015	109,132		20	5,457	5,457	10,913	17
18	Flooring: Hallways, Reception, Dining, Exercise Room, Offices	2016	20,583		20	1,029	1,029	1,029	18
19	Granite for Nursing Stations	2015	8,100		20	405	405	810	19
20	Draperies	2015	32,804		20	1,640	1,640	3,280	20
21	3 HVAC Roof Top Units	2016	55,811		20	2,791	2,791	2,791	21
22	Electirical work for Rooftop Units	2016	5,952		20	298	298	298	22
23	Fire Alarm System	2016	10,203		20	510	510	510	23
24	Fire Alarm System	2016	30,878		20	1,544	1,544	1,544	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 429,228	\$		\$ 18,790	\$ 18,790	\$ 84,841	34

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$429,228	\$		\$18,790	\$18,790	\$84,841	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
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$429,228	\$		\$18,790	\$18,790	\$84,841	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Related Party		\$	\$		\$	\$	\$	1
2 Buildings:								2
3								3
4								4
5								5
6								6
7								7
8 Leasehold Improvements:								8
9								9
10 ABH Management	2002	2,796	24	20	66	42	2,413	10
11 ABH Management	2003	167					167	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 TOTAL (lines 1 thru 33)		\$ 2,963	\$ 24		\$ 66	\$ 42	\$ 2,580	34

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

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 12H, Carried Forward		\$ 2,963	\$ 24		\$ 66	\$ 42	\$ 2,580	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,963	\$ 24		\$ 66	\$ 42	\$ 2,580	34

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

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	\$371,456	\$	\$26,627	\$26,627	10	\$318,304	71
72	Current Year Purchases	17,503		1,289	1,289	10	1,289	72
73	Fully Depreciated Assets	574,558				10	574,558	73
74								74
75	TOTALS	\$963,517	\$	\$27,916	\$27,916		\$894,151	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		Autos - See Attached	1900	\$203,373	\$	\$19,299	\$19,299	5	\$84,081	76
77										77
78										78
79										79
80	TOTALS			\$203,373	\$	\$19,299	\$19,299		\$84,081	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$5,485,002	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$167,689	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$153,737	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(13,952)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$3,931,509	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	FORD EXPEDITION - 1997	\$15,348	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$15,348	\$	\$	91

G. Construction-in-Progress

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

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

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

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	Alloc. ABH Mgmt.				17,725			5
6								6
7	TOTAL				\$ 17,725			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:

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$ 9,303

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	Facility	2016 Toyota Camry	\$	\$ 2,179	17
18					18
19					19
20					20
21	TOTAL		\$ -	\$ 2,179	21

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.	/2017	\$
13.	/2018	\$
14.	/2019	\$

* 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.

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

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 185,495	\$		\$ 185,495	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			4,106			4,106	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			180,721			180,721	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				136,307		136,307	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental						10,950		10,950	13
14	TOTAL			\$		\$ 370,322	\$ 147,257		\$ 517,579	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.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 355,923	\$ 445,918	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,161,025	1,161,025	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	17,408	26,708	6
7	Other Prepaid Expenses	11,829	11,829	7
8	Accounts Receivable (owners or related parties)	97,507	175,007	8
9	Other(specify): <u>See Attached Schedule</u>	77,000	280,093	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,720,692	\$ 2,100,580	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		202,513	13
14	Buildings, at Historical Cost		2,764,965	14
15	Leasehold Improvements, at Historical Cost	644,787	874,559	15
16	Equipment, at Historical Cost	934,945	1,363,941	16
17	Accumulated Depreciation (book methods)	(1,215,604)	(4,052,361)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		(13,273)	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	2,000	224,982	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 366,128	\$ 1,365,326	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,086,820	\$ 3,465,906	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 433,835	\$ 433,834	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	350,481	350,481	29
30	Accrued Salaries Payable	66,667	66,667	30
31	Accrued Taxes Payable (excluding real estate taxes)	47,820	47,820	31
32	Accrued Real Estate Taxes(Sch.IX-B)		98,000	32
33	Accrued Interest Payable		18,175	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	10,617	46,583	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 909,420	\$ 1,061,560	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	74,309	74,309	39
40	Mortgage Payable		5,521,571	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 74,309	\$ 5,595,880	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 983,729	\$ 6,657,440	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,103,091	\$ (3,191,534)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,086,820	\$ 3,465,906	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,127,559	1
2	Restatements (describe):		2
3	Adjustment	(31)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,127,528	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(24,437)	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)	\$ (24,437)	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)	\$ 1,103,091	24 *

* This must agree with page 17, line 47.

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	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 8,259,717	1
2	Discounts and Allowances for all Levels	(683,495)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,576,222	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	713,800	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 713,800	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	933	12
13	Barber and Beauty Care	10,671	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	120,394	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,945	19
20	Radiology and X-Ray		20
21	Other Medical Services	42,817	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 185,760	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,129	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,129	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	10,163	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 10,163	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,490,074	30

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,390,449	31
32	Health Care	3,298,980	32
33	General Administration	2,329,758	33
	B. Capital Expense		
34	Ownership	641,650	34
	C. Ancillary Expense		
35	Special Cost Centers	527,133	35
36	Provider Participation Fee	326,541	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,514,511	40
41	Income before Income Taxes (line 30 minus line 40)**	(24,437)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (24,437)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 5,241,489	44
45	Private Pay - Net Inpatient Revenue	890,787	45
46	Medicare - Net Inpatient Revenue	839,833	46
47	Other-(specify) Hospice	604,113	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,576,222	49

* This must agree with page 4, line 45, column 4.
** Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis 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.

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	2,048	2,112	\$ 78,278	\$ 37.06	1
2	Assistant Director of Nursing	1,770	1,986	57,256	28.83	2
3	Registered Nurses	17,952	19,057	498,482	26.16	3
4	Licensed Practical Nurses	20,907	22,010	523,456	23.78	4
5	CNAs & Orderlies	99,893	105,632	1,225,711	11.60	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,085	13,509	228,397	16.91	8
9	Activity Director	669	677	11,131	16.44	9
10	Activity Assistants	10,046	11,268	160,300	14.23	10
11	Social Service Workers	7,132	7,832	172,861	22.07	11
12	Dietician					12
13	Food Service Supervisor	2,071	2,215	44,105	19.91	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,664	24,597	300,484	12.22	15
16	Dishwashers					16
17	Maintenance Workers	2,158	2,358	43,626	18.50	17
18	Housekeepers	17,200	18,851	235,070	12.47	18
19	Laundry	9,061	10,020	125,075	12.48	19
20	Administrator	2,160	2,160	216,678	100.31	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,192	11,794	199,096	16.88	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					31
32	Other Health Care(specify)					32
33	Other(specify)	796	796	9,554	12.00	33
34	TOTAL (lines 1 - 33)	238,804	256,874	\$ 4,129,560 *	\$ 16.08	34

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	Monthly	\$ 8,136	01-03	35
36	Medical Director	Monthly	33,729	09-03	36
37	Medical Records Consultant	Monthly	3,600	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	15,852	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 61,317		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

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

** See instructions.

Facility Name & ID Number		Hillcrest Retirement Village		STATE OF ILLINOIS	#	0030312	Report Period Beginning:	01/01/16	Ending:	12/31/16	Page 22
XX. GENERAL INFORMATION:											
(1)	Are nursing employees (RN,LPN,NA) represented by a union?			<u>Yes</u>							
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount.			<u>Yes</u> <u>ICLTC \$14,819</u>							
(3)	Did the nursing home make political contributions or payments to a political action organization? If YES, have these costs been properly adjusted out of the cost report?			<u>Yes</u> <u>Yes</u>							
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? If YES, what is the capacity?			<u>No</u> <u>N/A</u>							
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period?			<u>Yes</u> <u>10 Years</u>							
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.			\$ <u>46,548</u> Line <u>10</u>							
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? If NO, attach a complete explanation.			<u>Yes</u>							
(8)	Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease.			<u>No</u>							
(9)	Are you presently operating under a sublease agreement?			YES <u>X</u> NO							
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES <u>NO</u> <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.			<u>N/A</u>							
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. This amount is to be recorded on line 42 of Schedule V.			\$ <u>326,541</u>							
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? If YES, attach an explanation of the allocation.			<u>No</u>							
(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?			<u>N/A</u>							
(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? 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.			<u>No</u>							
(15)	Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. Has any meal income been offset against related costs?			\$ <u>30,305</u> <u>N/A</u> Indicate the amount. \$							
(16)	Travel and Transportation										
	a. Are there costs included for out-of-state travel? If YES, attach a complete explanation.			<u>No</u>							
	b. Do you have a separate contract with the Department to provide medical transportation for residents? If YES, please indicate the amount of income earned from such a program during this reporting period.			<u>No</u> \$ <u>N/A</u>							
	c. What percent of all travel expense relates to transportation of nurses and patients?			<u>100% ln 14</u>							
	d. Have vehicle usage logs been maintained?			<u>N/A</u>							
	e. Are all vehicles stored at the nursing home during the night and all other times when not in use?			<u>N/A</u>							
	f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?			<u>N/A</u>							
	g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period.			<u>No</u> \$ <u>N/A</u>							
(17)	Has an audit been performed by an independent certified public accounting firm? Firm Name:			<u>No</u> <u>N/A</u>							
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?			<u>Yes</u>							
(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. Attach invoices and a summary of services for all architect and appraisal fees			<u>Yes</u>							