

		FOR BHF USE					

LL1

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

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

I. IDPH License ID Number: 0030312

Facility Name: Hillcrest Retirement Village

Address: 1740 N Circuit Drive Round Lake Beach 60073
Number City Zip Code

County: Lake

Telephone Number: (847) 546-5301 Fax # (847) 546-7563

HFS ID Number:

Date of Initial License for Current Owners: 11/29/1985

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda Telephone Number: (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/20 to 12/31/20 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date) _____
(Type or Print Name) _____
(Title) _____

Paid Preparer

(Signed) 04/14/2021 (Date)
* Subject to the attached Accountants' Consulting Report
(Print Name and Title) Steven N. Lavenda, CPA Partner
(Firm Name & Address) Marcum, LLP 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Hillcrest Retirement Village

0030312 Report Period Beginning: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA

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

N/A

	1	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	<u>57</u>	Skilled (SNF)	<u>57</u>	<u>20,862</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>87</u>	Intermediate (ICF)	<u>87</u>	<u>31,842</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>144</u>	TOTALS	<u>144</u>	<u>52,704</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF		<u>5,721</u>	<u>3,064</u>	<u>8,785</u>	8
9	SNF/PED					9
10	ICF	<u>33,683</u>			<u>33,683</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>33,683</u>	<u>5,721</u>	<u>3,064</u>	<u>42,468</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.58%

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

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

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

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

☐

NO

☒

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

1,956

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: 12/31/20

Fiscal Year: 12/31/20

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

Facility Name & ID Number Hillcrest Retirement Village # 0030312 Report Period Beginning: 01/01/20 Ending: 12/31/20
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	783,554	55,915	8,836	848,305		848,305		848,305			1
2	Food Purchase		337,312		337,312	(38,540)	298,772	(454)	298,318			2
3	Housekeeping	370,276	16,590		386,866		386,866		386,866			3
4	Laundry	194,001	25,868		219,869		219,869		219,869			4
5	Heat and Other Utilities			105,670	105,670		105,670	(2,093)	103,577			5
6	Maintenance	50,129	20,307	78,732	149,168		149,168	(17,485)	131,683			6
7	Other (specify):*											7
8	TOTAL General Services	1,397,960	455,992	193,238	2,047,190	(38,540)	2,008,650	(20,032)	1,988,618			8
	B. Health Care and Programs											
9	Medical Director			36,333	36,333		36,333		36,333			9
10	Nursing and Medical Records	2,982,721	1,145,200	74,045	4,201,966		4,201,966		4,201,966			10
10a	Therapy	225,353			225,353		225,353		225,353			10a
11	Activities	262,976	5,837	325	269,138		269,138		269,138			11
12	Social Services	162,246			162,246		162,246		162,246			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,633,296	1,151,037	110,703	4,895,036		4,895,036		4,895,036			16
	C. General Administration											
17	Administrative	237,705		223,950	461,655		461,655	(88,950)	372,705			17
18	Directors Fees											18
19	Professional Services			240,694	240,694	(785)	239,909	(11,622)	228,287			19
20	Dues, Fees, Subscriptions & Promotions			233,756	233,756		233,756	(155,308)	78,448			20
21	Clerical & General Office Expenses	333,300	1,003	542,260	876,563		876,563	(427,511)	449,052			21
22	Employee Benefits & Payroll Taxes			964,382	964,382	38,540	1,002,922	(29,124)	973,798			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,595	6,595		6,595	(338)	6,257			24
25	Other Admin. Staff Transportation			546	546		546		546			25
26	Insurance-Prop.Liab.Malpractice			234,165	234,165		234,165	13,840	248,005			26
27	Other (specify):*							13,514	13,514			27
28	TOTAL General Administration	571,005	1,003	2,446,348	3,018,356	37,755	3,056,111	(685,499)	2,370,612			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,602,261	1,608,032	2,750,289	9,960,582	(785)	9,959,797	(705,531)	9,254,266			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			47,055	47,055		47,055	96,413	143,468			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,593	9,593		9,593	191,714	201,307			32
33	Real Estate Taxes					785	785	79,058	79,843			33
34	Rent-Facility & Grounds			552,000	552,000		552,000	(530,083)	21,917			34
35	Rent-Equipment & Vehicles			9,996	9,996		9,996	697	10,693			35
36	Other (specify):*							33,836	33,836			36
37	TOTAL Ownership			618,644	618,644	785	619,429	(128,365)	491,064			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	1,680	73,664	379,377	454,721		454,721		454,721			39
40	Barber and Beauty Shops	1,176			1,176		1,176		1,176			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			341,729	341,729		341,729		341,729			42
43	Other (specify):*			29,711	29,711		29,711	(29,711)	(0)			43
44	TOTAL Special Cost Centers	2,856	73,664	750,817	827,337		827,337	(29,711)	797,626			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	5,605,117	1,681,696	4,119,750	11,406,563		11,406,563	(863,608)	10,542,955			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	(2,460)	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	57,012	30		9
10	Interest and Other Investment Income	(5,012)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(454)	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	(87,623)	21		18
19	Entertainment				19
20	Contributions	(488)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(319,812)	21		24
25	Fund Raising, Advertising and Promotional	(142,320)	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	(136,041)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (637,198)		\$	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)	(226,409)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (226,409)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (863,607)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non Allowable Expense	\$ (201)	43	1
2	Bank Charges	(26,061)	21	2
3	Non Allowable Insurance	(5,124)	22	3
4	Gain on Sale of Auto	(19,950)	30	4
5	Bldg Co - Amortization	(6,371)	36	5
6	Bldg Co - Accounting	(5,200)	19	6
7	Bldg Co - State Replacement Tax	(1,500)	21	7
8	Capitalized R&M	(17,485)	06	8
9	Chamber of Commerce Dues	(175)	20	9
10	PAC Dues	(12,325)	20	10
11	Non Allowable Legal	(11,801)	19	11
12	Non Allowable Seminar	(338)	24	12
13	Non Allowable Expense	(29,510)	43	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	(136,041)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hillcrest Retirement Village # 0030312 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	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	(454)											(454)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(2,460)		367									(2,093)	5
6	Maintenance	(17,485)											(17,485)	6
7	Other (specify):*													7
8	TOTAL General Services	(20,399)		367									(20,032)	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			(36,000)	30,050	(83,000)							(88,950)	17
18	Directors Fees													18
19	Professional Services	(17,001)	5,200	179									(11,622)	19
20	Fees, Subscriptions & Promotions	(155,308)											(155,308)	20
21	Clerical & General Office Expenses	(434,996)	1,500	5,985									(427,511)	21
22	Employee Benefits & Payroll Taxes	(5,124)		(24,000)									(29,124)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(338)											(338)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice		13,840										13,840	26
27	Other (specify):*			8,644	4,870								13,514	27
28	TOTAL General Administration	(612,767)	20,540	(45,192)	34,920	(83,000)							(685,499)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(633,166)	20,540	(44,825)	34,920	(83,000)							(705,531)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Hillcrest Retirement Village # 0030312 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	37,062	59,313	38									96,413	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(5,012)	196,726										191,714	32
33	Real Estate Taxes		79,058										79,058	33
34	Rent-Facility & Grounds		(552,000)	21,917									(530,083)	34
35	Rent-Equipment & Vehicles			697									697	35
36	Other (specify):*	(6,371)	40,207										33,836	36
37	TOTAL Ownership	25,679	(176,696)	22,652									(128,365)	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):*	(29,711)											(29,711)	43
44	TOTAL Special Cost Centers	(29,711)											(29,711)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(637,198)	(156,156)	(22,173)	34,920	(83,000)							(863,608)	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 Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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

☒ YES ☐ 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		Hillcrest Development, LLC		79,058	79,058	3
4	V	19	Accounting		Hillcrest Development, LLC		5,200	5,200	4
5	V	30	Depreciation		Hillcrest Development, LLC		59,313	59,313	5
6	V	26	Insurance		Hillcrest Development, LLC		13,840	13,840	6
7	V	36	MIP Expense		Hillcrest Development, LLC		33,836	33,836	7
8	V	21	State Replacement Tax		Hillcrest Development, LLC		1,500	1,500	8
9	V	32	Interest	612	Hillcrest Development, LLC		197,338	196,726	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 552,612			\$ 396,456	\$ * (156,156)	14

* 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	32.50%	ABBOTT HOUSE LLC	HIGHLAND PARK	HILLCREST DEVELOPMENT, LLC		BUILDING CO.	1
2	EARL ROSENBAUM TRUSTEE	33.75%	BAYSIDE TERRACE LLC	WAUKEGAN	KARLA BISHOP, INC.	LAKE BLUFF	MANAGEMENT CO.	2
3	MARVIN FOX	4.04%			A.H.B. D/B/A ABH MANAGEMEN	HIGHLAND PARK	HOME OFFICE	3
4	ROBERT A. ROSE LIVING TRUST	4.04%			HEALTH RESOURCE, INC.	HIGHLAND PARK	MANAGEMENT CO.	4
5	RICHARD S. SGARLATA	2.53%			HILLCREST CONSULTING, LLC	ROUND LAKE BEACH	CONSULTING CO.	5
6	NOSHIR DARUWALLA	2.53%						6
7	ARTHUR ROTHBLATT	2.53%						7
8	LAWRENCE SAVITT REVOCABLE TRUST	4.00%						8
9	JUDY ROSENBAUM	2.50%						9
10	ILA ROSENBAUM	0.31%						10
11	RALPH ROSENBAUM	0.31%						11
12	MITCHELL ROSENBAUM	0.31%						12
13	PAUL ROSENBAUM	0.31%						13
14	GAIL GOODSITE REVOCABLE TRUST	3.22%						14
15	EDWARD G ROTHBLATT ADMIN TRUST	4.04%						15
16	BETTE COHN	1.89%						16
17	ALAN ROSENBAUM FAMILY TRUST	0.50%						17
18	IVY FISHMAN FAMILY TRUST	0.50%						18
19	GAIL GOODSITE ADMINISTRATIVE TRUST	0.19%						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)

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		\$ 367	\$ 367	15
16	V	19	Professional Fees		A.H.B. D/B/A ABH Management		179	179	16
17	V	21	Clerical & General		A.H.B. D/B/A ABH Management		5,985	5,985	17
18	V	30	Depreciation		A.H.B. D/B/A ABH Management		38	38	18
19	V	34	Rent		A.H.B. D/B/A ABH Management		21,917	21,917	19
20	V	35	Equipment Rental		A.H.B. D/B/A ABH Management		697	697	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V	27	Emp. Ben. - Direct Allocation		A.H.B. D/B/A ABH Management		8,644	8,644	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V	17	Home Office	36,000	A.H.B. D/B/A ABH Management			(36,000)	33
34	V	22	Home Office Benefits	24,000	A.H.B. D/B/A ABH Management			(24,000)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 60,000			\$ 37,827	\$ * (22,173)	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.		\$ 50,000	\$ 50,000	15
16	V	27	Employee Benefits		Karla Bishop, Inc.		4,870	4,870	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V	17	Management Fees	19,950	Karla Bishop, Inc.			(19,950)	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			\$ 19,950			\$ 54,870	\$ * 34,920	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 Inc.		Hillcrest Consulting LLC		\$ 75,000	\$ 75,000	15
16	V	17	Management Fee - A. Rosenbaum		Hillcrest Consulting LLC		10,000	10,000	16
17	V								17
18	V	17	Management Fee	168,000	Hillcrest Consulting LLC			(168,000)	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			\$ 168,000			\$ 85,000	\$ * (83,000)	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.

YESNO

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.

YESNO

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.

YESNO

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.

Facility Name & ID Number Hillcrest Retirement Village # 0030312 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Alan Rosenbaum	Administrator	Administrative	0	None	50	100.00%	Sal,Mgmt Fee	\$ 247,705	17-01,17-07	1
2	Karla Bishop	President	Administrative	32.50%	See Attached	10	25.00%	Alloc-Admin	50,000	17-07	2
3	Michele Rosenbaum	Bookkeeper	Clerical	0	None	40	100.00%	Salary	49,870	21-07	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	\$ 347,575		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: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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 Avenue
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	5	Utilities	Patient Days	111,701	3	\$ 965	\$	42,468	\$ 367	1
2	19	Professional Fees	Patient Days	111,701	3	471		42,468	179	2
3	21	Clerical & General	Patient Days	111,701	3	15,743		42,468	5,985	3
4	30	Depreciation	Patient Days	111,701	3	101		42,468	38	4
5	34	Rent	Patient Days	111,701	3	57,647		42,468	21,917	5
6	35	Equipment Rental	Patient Days	111,701	3	1,833		42,468	697	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14	27	Emp. Ben. - Direct Allocation	Direct		1	8,644			8,644	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 85,404	\$		\$ 37,827	25

Facility Name & ID Number Hillcrest Retirement Village # 0030312 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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	Average Hours Worked	40	3	\$ 200,000	\$ 200,000	10	\$ 50,000	1
2	27	Employee Benefits	Average Hours Worked	40	3	19,479		10	4,870	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					\$ 219,479	\$ 200,000		\$ 54,870	25

Facility Name & ID Number Hillcrest Retirement Village # 0030312 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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 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	Management Fee- K. Bishop Inc.				\$	\$		\$ 75,000	1
2	17	Management Fee - A. Rosenbaum							10,000	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					\$	\$		\$ 85,000	25

Facility Name & ID Number Hillcrest Retirement Village # 0030312 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- 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: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- 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: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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 Mortgage		X	Mortgage			\$	5,176,784			\$	197,338	1	
2													2	
3													3	
4													4	
5													5	
	Working Capital													
6	Auto Loan		X					39,167				2,243	6	
7	Lake Forest Bank		X	Line of Credit								7,350	7	
8													8	
9	TOTAL Facility Related						\$	5,215,951				\$	206,931	9
	B. Non-Facility Related*													
10	Interest Income		X									(5,012)	10	
11	Interest Income - Bldg Co.		X									(612)	11	
12													12	
13													13	
14	TOTAL Non-Facility Related						\$					\$	(5,624)	14
15	TOTALS (line 9+line14)						\$	5,215,951				\$	201,307	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 33,836 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 (continued)

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2019 report.			\$	96,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	86,059	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(9,941)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	89,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	785	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	79,844	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	95,090	8	
		2016	96,346	9	
		2017	95,816	10	
		2018	93,218	11	
		2019	86,059	12	
2020 Accrual = \$86,059 x 1.03 = \$89,000 (Rounded)					

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

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Hillcrest Retirement Village COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0030312

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 282-6330 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 06-17-200-009	Long Term Care Property	\$ 2,670.36	\$ 2,670.36
2. 06-17-200-010	Long Term Care Property	\$ 70,375.10	\$ 70,375.10
3. 06-17-200-011	Long Term Care Property	\$ 1,355.48	\$ 1,355.48
4. 06-17-214-011	Parking Lot	\$ 5,695.76	\$ 5,695.76
5. 06-17-214-010	Parking Lot	\$ 5,962.20	\$ 5,962.20
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 86,058.90	\$ 86,058.90

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

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

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation . Facilities located in Cook County are required to provide copies of their original second installment tax bill.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2019 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 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

Please complete the Real Estate Tax Statement below and include it in the 2020 cost report along with a copy of your 2019 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 Steven Lavenda

TELEPHONE () FAX #: ()

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

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.

Page 10B

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

24,277

B. General Construction Type:

Exterior

Brick

Frame

Number 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	45,104	31.6	24,709	(20,395)	776,693	5
6			1994	1994	554,167	14,209	39	14,209	0	354,613	6
7											7
8											8
	Improvement Type**										
9	Various		1987		9,045		20			9,045	9
10	Various		1989		36,275		20	10	10	36,275	10
11	Various		1990		2,002		20	2	2	2,002	11
12	Various		1991		16,248		20	704	704	16,238	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	279	279	7,318	16
17	Various		1996		51,722		20	3	3	51,722	17
18	Various		1997		4,495		20	3	3	4,495	18
19	Various		1998		24,327		20	4	4	24,327	19
20	Various		1999		9,947		20	18	18	9,947	20
21	Various		2000		7,062		20	351	351	7,061	21
22	Various		2001		32,994		20	1,651	1,651	23,552	22
23	Various		2002		6,950		20			6,950	23
24	Various		2003		10,904		20	441	441	9,858	24
25	Various		2004		8,143		20	367	367	6,930	25
26	Various		2005		7,695		20	202	202	6,763	26
27	Various		2006		30,616		20	730	730	26,446	27
28	Various		2007		10,035		20			10,035	28
29	Various		2009		8,713		20	283	283	6,303	29
30	Various		2010		34,981		20	1,425	1,425	26,273	30
31	Various		2011		32,168		20	1,348	1,348	28,863	31
32	Various		2013		348,435		20	17,422	17,422	179,632	32
33	Various		2014		74,893		20	3,316	3,316	41,700	33
34	Various		2015		26,483		20	1,323	1,323	7,400	34
35	Various		2016		64,521		20	3,226	3,226	14,798	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

Facility Name & ID Number Hillcrest Retirement Village

0030312

Report Period Beginning:

01/01/20

Ending:

12/31/20

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	160,000	67
68	Related Party Allocations (Pages 12H & 12I)	3,431	38		76	38	3,294	68
69	Financial Statement Depreciation		27,105			(27,105)		69
70	TOTAL (lines 4 thru 69)	\$ 4,128,566	\$ 86,456		\$ 90,892	\$ 4,436	\$ 3,352,022	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:

01/01/20

Ending:

12/31/20

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		\$ 4,128,566	\$ 86,456		\$ 90,892	\$ 4,436	\$ 3,352,022	1
2	Fire Alarm Upgrade	2017	2,706		20	135	135	485	2
3	Reinstall Bedroom Doors	2017	6,913		20	346	346	1,297	3
4	Demo Rm. 200/202/Bathrooms/Build Walls/Paint/New Doors	2017	7,275		20	364	364	1,455	4
5	Refurbish & Reinstall Doors	2017	3,420		20	171	171	656	5
6	2 Roof Curbs/Goose Necks/Ductwork/Fire Dampers/Access Doors	2017	8,420		20	421	421	1,403	6
7	Hallway Closet Door & Men'S Shower Wall	2018	4,988		20	249	249	706	7
8	Hardware Shower Room, Paint Doors, Men'S Shower Walls	2018	3,465		20	173	173	447	8
9	Bathroom Tile	2018	7,093		20	355	355	1,005	9
10	Kitchen Flooring & Paint	2018	4,400		20	220	220	623	10
11	Bathroom Plumbing, Electric, Drywall	2018	7,050		20	353	353	1,029	11
12	Women'S Shower Walls & Doors	2018	2,608		20	130	130	391	12
13	Women'S Shower Walls & Doors	2018	14,815		20	741	741	1,852	13
14	Kitchen Wall Tiles, Plumbing, Electrical	2018	3,240		20	162	162	486	14
15	Install Vinyl Tiles In Resident Rooms	2018	2,640		20	132	132	374	15
16	Fire Alarm System Installation	2019	18,202		20	910	910	1,820	16
17	Network Repairs, Install 5E Data Cables, Jacks	2019	5,941		20	297	297	594	17
18	Water Heater	2020	16,995		20	850	850	850	18
19	Seal Coat & Stripe Parking Lot	2020	8,985		20	449	449	449	19
20	Replace Vents Top Of Roof	2020	8,500		20	425	425	425	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)		\$ 4,266,222	\$ 86,456		\$ 97,775	\$ 11,319	\$ 3,368,369	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		\$ 4,266,222	\$ 86,456		\$ 97,775	\$ 11,319	\$ 3,368,369	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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,266,222	\$ 86,456		\$ 97,775	\$ 11,319	\$ 3,368,369	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 12C, Carried Forward		\$ 4,266,222	\$ 86,456		\$ 97,775	\$ 11,319	\$ 3,368,369	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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,266,222	\$ 86,456		\$ 97,775	\$ 11,319	\$ 3,368,369	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		\$4,266,222	\$86,456		\$97,775	\$11,319	\$3,368,369	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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$4,266,222	\$86,456		\$97,775	\$11,319	\$3,368,369	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:

01/01/20

Ending:

12/31/20

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	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	1,740	10
11	Retention Pond	2015	30,590		20	1,530	1,530	9,177	11
12	Flooring, Hand/Crash Rails, Drywall Doors/Carpentry -	2015	22,000		20	1,100	1,100	6,600	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	3,347	14
15	Corner Guards/Handrails, Wallcovering-100-500 wings/corridors	2015	26,582		20	1,329	1,329	7,974	15
16	Wander Protection System	2015	6,203		20	310	310	1,861	16
17	Flooring: Hallways, Reception, Dining, Exercise Room, Offices	2015	109,132		20	5,457	5,457	32,739	17
18	Flooring: Hallways, Reception, Dining, Exercise Room, Offices	2016	20,583		20	1,029	1,029	5,146	18
19	Granite for Nursing Stations	2015	8,100		20	405	405	2,430	19
20	Draperies	2015	32,804		20	1,640	1,640	9,841	20
21	3 HVAC Roof Top Units	2016	55,811		20	2,791	2,791	13,953	21
22	Electirical work for Rooftop Units	2016	5,952		20	298	298	1,488	22
23	Fire Alarm System	2016	10,203		20	510	510	2,551	23
24	Fire Alarm System	2016	30,878		20	1,544	1,544	7,720	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	\$ 160,000	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	\$160,000	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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$429,228	\$		\$18,790	\$18,790	\$160,000	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:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from ABH Management	2002	3,238	38	20	76	38	3,100	9
10	Allocated from ABH Management	2003	193		20			193	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,431	\$ 38		\$ 76	\$ 38	\$ 3,294	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 12H, Carried Forward		\$3,431	\$38		\$76	\$38	\$3,294	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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$3,431	\$38		\$76	\$38	\$3,294	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	\$227,917	\$	\$8,211	\$8,211	10	\$202,084	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	746,948		75	75	10	746,948	73
74								74
75	TOTALS	\$974,865	\$	\$8,286	\$8,286		\$949,032	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		VAN	1993	\$19,682	\$	\$	\$	5	\$19,682	76
77		FORD EXPEDITION	1997	23,022				5	23,022	77
78		CHEVY SILVERADO 2500	2014	58,364		11,673	11,673	5	56,141	78
79		See Attached		128,671		25,734	25,734		68,817	79
80	TOTALS			\$229,739	\$	\$37,407	\$37,407		\$167,662	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$5,660,839	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$86,456	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$143,468	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$57,012	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$4,485,063	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	Allocated from ABH Mgmt				21,917			5
6								6
7	TOTAL				\$ 21,917			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?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$ 10,693
- Description: See Attached

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2021	\$
13.	/2022	\$
14.	/2023	\$

* 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.)

12345678										
	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	\$		\$ 173,142	\$		\$ 173,142	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			27,122			27,122	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			179,113			179,113	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				63,649		63,649	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached			1,680			10,015		11,695	13
14	TOTAL			\$ 1,680		\$ 379,377	\$ 73,664		\$ 454,721	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	\$ 724,009	\$ 982,784	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,190,991	1,190,991	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	42,454	51,937	6
7	Other Prepaid Expenses	80,017	34,017	7
8	Accounts Receivable (owners or related parties)		94,985	8
9	Other(specify): See Attached	7,500	460,492	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,044,971	\$ 2,815,206	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	985,416	1,414,412	16
17	Accumulated Depreciation (book methods)	(1,421,636)	(4,595,405)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached	208,443	392,668	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 417,010	\$ 1,053,712	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,461,981	\$ 3,868,918	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 874,567	\$ 876,068	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	11,330	125,499	29
30	Accrued Salaries Payable	183,604	183,604	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,994	10,994	31
32	Accrued Real Estate Taxes(Sch.IX-B)		89,000	32
33	Accrued Interest Payable		12,726	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	1,345,130	1,345,130	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,425,625	\$ 2,643,021	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	27,837	27,837	39
40	Mortgage Payable		5,062,615	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	6,481	6,481	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 34,318	\$ 5,096,933	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,459,943	\$ 7,739,954	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,038	\$ (3,871,036)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,461,981	\$ 3,868,918	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 806,552	1
2	Restatements (describe):		2
3	Pension Plan Contribution	(10,690)	3
4	Rounding	(1)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 795,861	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(793,823)	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)	\$ (793,823)	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)	\$ 2,038	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Hillcrest Retirement Village

0030312

Report Period Beginning:

01/01/20

Ending:

12/31/20

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 9,333,836	1
2	Discounts and Allowances for all Levels	(374,497)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,959,339	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	509,980	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 509,980	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,796	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	77,657	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,619	19
20	Radiology and X-Ray	2,200	20
21	Other Medical Services	50,386	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 133,658	23
	D. Non-Operating Revenue		
24	Contributions	300	24
25	Interest and Other Investment Income***	5,012	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,312	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	1,004,451	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,004,451	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,612,740	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,047,190	31
32	Health Care	4,895,036	32
33	General Administration	3,018,356	33
	B. Capital Expense		
34	Ownership	618,644	34
	C. Ancillary Expense		
35	Special Cost Centers	485,608	35
36	Provider Participation Fee	341,729	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,406,563	40
41	Income before Income Taxes (line 30 minus line 40)**	(793,823)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (793,823)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 6,566,936	44
45	Private Pay - Net Inpatient Revenue	1,259,619	45
46	Medicare - Net Inpatient Revenue	853,496	46
47	Other-(specify) Hospice	279,288	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,959,339	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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	2,101	2,259	\$ 107,257	\$ 47.48	1
2	Assistant Director of Nursing	3,775	4,047	153,495	37.93	2
3	Registered Nurses	19,832	21,467	651,572	30.35	3
4	Licensed Practical Nurses	12,394	13,380	380,999	28.48	4
5	CNAs & Orderlies	90,153	97,993	1,689,398	17.24	5
6	CNA Trainees					6
7	Licensed Therapist	56	56	1,680	30.00	7
8	Rehab/Therapy Aides	9,389	11,194	225,353	20.13	8
9	Activity Director	2,017	2,337	44,401	19.00	9
10	Activity Assistants	11,322	12,910	218,575	16.93	10
11	Social Service Workers	5,523	7,771	162,246	20.88	11
12	Dietician					12
13	Food Service Supervisor	1,996	2,080	51,483	24.75	13
14	Head Cook					14
15	Cook Helpers/Assistants	39,677	43,910	732,071	16.67	15
16	Dishwashers					16
17	Maintenance Workers	1,840	2,080	50,129	24.10	17
18	Housekeepers	18,503	20,863	370,276	17.75	18
19	Laundry	9,784	10,688	194,001	18.15	19
20	Administrator	2,072	2,080	237,705	114.28	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,619	15,748	333,300	21.16	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) See Attached	98	98	1,176	12.00	33
34	TOTAL (lines 1 - 33)	245,151	270,961	\$ 5,605,117 *	\$ 20.69	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 8,836	01-03	35
36	Medical Director	Monthly	36,333	09-03	36
37	Medical Records Consultant	Monthly	4,800	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	16,110	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	Monthly	325	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 66,404		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	2,134	53,135	10-03	52
53	TOTAL (lines 50 - 52)	2,134	\$ 53,135		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Alan Rosenbaum	Administrator	0	\$ 237,705
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 237,705
B. Administrative - Other			
Description			Amount
Hillcrest Consulting LLC - Management Fee		\$	168,000
ABH - Home Office Expense			36,000
Karla Bishop, Inc. - Management Fee			19,950
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 223,950
C. Professional Services			
Vendor/Payee	Type		Amount
Marcum LLP	Accounting	\$	128,264
Profit Planners	Pension Administration Fee		2,642
Personnel Planners	Unemployment Tax Consult		1,650
Alpha Data	Data Processing		12,175
See Attached	Legal		95,963
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 240,694
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance	\$		86,305
Unemployment Compensation Insurance			63,179
FICA Taxes			428,791
Employee Health Insurance			243,358
Employee Meals			38,540
Illinois Municipal Retirement Fund (IMRF)*			
Other Employee Benefits			6,085
Pension Contribution			97,228
Christmas Expense			10,311
TOTAL (agree to Schedule V, line 22, col.8)			\$ 973,797
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
		\$	
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee	\$		
Advertising: Employee Recruitment			49,241
Health Care Worker Background Check (Indicate # of checks performed _____)			
Patient Background Checks			
Dues & Subscriptions			19,831
Licenses & Fees			9,376
Less: Public Relations Expense	(		)
Non-allowable advertising	(		)
Yellow page advertising	(		)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 78,448
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel	\$		
In-State Travel			
Seminar Expense			6,257
Entertainment Expense	(		)
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	6,257

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

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

Yes

(2) Are there any dues to nursing home associations included on the cost report?

Yes

If YES, give association name and amount. HCCI \$24,649

(3) Did the nursing home make political contributions or payments to a political action organization?

Yes

If YES, have these costs been properly adjusted out of the cost report?

Yes

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

N/A

(5) Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

10 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 61,183

Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A

(9) Are you presently operating under a sublease agreement?

YES

X

NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 341,729

This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.

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

N/A

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

No

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ 38,540

Has any meal income been offset against related costs?

N/A

Indicate the amount. \$

(16) Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$ N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

100% Ln 14

d. Have vehicle usage logs been maintained?

N/A

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

N/A

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$ N/A

(17) Has an audit been performed by an independent certified public accounting firm?

No

Firm Name:

N/A

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

Yes

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility?

See page 39 of the instructions for details.

Yes

Attach invoices and a summary of services for all architect and appraisal fees.

HFS 3745 (N-4-99)

IL478-2471