

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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

I. IDPH License ID Number: 0001099

Facility Name: Hillcrest Home

Address: 14688 IL Hwy 82 Geneseo 61254

County: Henry

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

HFS ID Number:

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

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

X

GOVERNMENTAL

State

X

County

Other

In the event there are further questions about this report, please contact:

Name: Jeremy M. Brune, CPA Telephone Number: (779) 875 - 3979

Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/01/24 to 11/30/25 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) 04/29/26

(Type or Print Name) Kevin Powell

(Title) Administrator

Paid Preparer

(Signed) 04/29/26

(Print Name and Title) Jeremy M. Brune, CPA CEO

(Firm Name & Address) Jeremy Brune & Associates, LLC 2508 Riverwalk Drive Plainfield, Illinois 60586

(Telephone) (779) 875 - 3979 Fax # (866) 216 - 5355

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

Facility Name & ID Number

Hillcrest Home

#

0001099

Report Period Beginning:

12/01/24

Ending:

11/30/25

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	99	Skilled (SNF)	99	36,135	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF	2,374	4,839			9,572	554	1,444	18,783	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	2,374	4,839			9,572	554	1,444	18,783	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.)

51.98%

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

0

(Do not include bed reserve days in Section B.)

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

N/A

F. Does the facility maintain a daily midnight census?

Yes

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

YESNO

X

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

YESNO

X

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

Date started

06/10/56

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

YESDateNO

X

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

YES

X

NOIf YES, enter certified beds. number of certified beds

99

Medicare Intermediary

Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUL

X

MODIFIED CASH*CASH*

Is your fiscal year identical to your tax year?

YES

X

NO

Tax Year:

11/30/25

Fiscal Year:

11/30/25

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

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/24 Ending: 11/30/25

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	580,022	21,123	5,779	606,924		606,924		606,924			1
2	Food Purchase		212,426		212,426		212,426	(3,792)	208,634			2
3	Housekeeping	155,619	24,465		180,084		180,084		180,084			3
4	Laundry	78,676	17,596		96,272		96,272		96,272			4
5	Heat and Other Utilities			99,712	99,712		99,712	(11,912)	87,800			5
6	Maintenance	153,761	8,443	85,429	247,633		247,633		247,633			6
7	Other (specify):* See Supplemental											7
8	TOTAL General Services	968,078	284,053	190,920	1,443,051		1,443,051	(15,704)	1,427,347			8
	B. Health Care and Programs											
9	Medical Director			11,000	11,000		11,000		11,000			9
10	Nursing and Medical Records	1,800,594	99,150	732,419	2,632,163		2,632,163		2,632,163			10
10a	Therapy											10a
11	Activities	93,234	6,517		99,751		99,751	(2,240)	97,511			11
12	Social Services	64,021		1,250	65,271		65,271		65,271			12
13	CNA Training											13
14	Program Transportation			4,776	4,776		4,776	(2,535)	2,241			14
15	Other (specify):* See Supplemental											15
16	TOTAL Health Care and Programs	1,957,849	105,667	749,445	2,812,961		2,812,961	(4,775)	2,808,186			16
	C. General Administration											
17	Administrative	86,198			86,198		86,198		86,198			17
18	Directors Fees											18
19	Professional Services			10,006	10,006		10,006		10,006			19
20	Dues, Fees, Subscriptions & Promotions			12,162	12,162		12,162	(60)	12,102			20
21	Clerical & General Office Expenses	215,604	11,251	140,481	367,336		367,336	18,707	386,043			21
22	Employee Benefits & Payroll Taxes			1,353,314	1,353,314		1,353,314		1,353,314			22
23	Inservice Training & Education			197	197		197		197			23
24	Travel and Seminar			1,693	1,693		1,693		1,693			24
25	Other Admin. Staff Transportation			60	60		60		60			25
26	Insurance-Prop.Liab.Malpractice			122,328	122,328		122,328		122,328			26
27	Other (specify):* See Supplemental											27
28	TOTAL General Administration	301,802	11,251	1,640,241	1,953,294		1,953,294	18,647	1,971,941			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,227,729	400,971	2,580,606	6,209,306		6,209,306	(1,832)	6,207,474			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 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	
	D. Ownership											
30	Depreciation			282,497	282,497		282,497		282,497			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* See Supplemental											36
37	TOTAL Ownership			282,497	282,497		282,497		282,497			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	222,587	39,267	34,788	296,642		296,642		296,642			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			127,176	127,176		127,176		127,176			42
43	Other (specify):* See Supplemental											43
44	TOTAL Special Cost Centers	222,587	39,267	161,964	423,818		423,818		423,818			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,450,316	440,238	3,025,067	6,915,621		6,915,621	(1,832)	6,913,789			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	(3,792)	02		4
5	Telephone, TV & Radio in Resident Rooms	(11,912)	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				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(59,522)	21		24
25	Fund Raising, Advertising and Promotional	(60)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Supplemental Schedule	(7,096)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (82,382)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	80,550		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 80,550		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,832)		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	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4	Miscellaneous Income	(1,198)	21	4
5	Transportation Income	(2,535)	14	5
6	Activity Income	(2,240)	11	6
7	Public Relations	(195)	21	7
8	Late Payment Interest and Fines	(928)	21	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(7,096)		49

Summary A

11/30/25

[illegible]

Summary B

11/30/25

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Henry County	100.00%					

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

☒

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	22	IMRF	\$ 193,810	Henry County	100.00%	\$ 193,810		1
2	V	22	FICA	256,713	Henry County	100.00%	256,713		2
3	V	22	FUTA	1,596	Henry County	100.00%	1,596		3
4	V	22	Workers Compensation	49,396	Henry County	100.00%	49,396		4
5	V	26	Property / Casualty Insurance	122,328	Henry County	100.00%	122,328		5
6	V	21	Administrative Support		Henry County	100.00%	80,550	80,550	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 623,843			\$ 704,393	\$ * 80,550	14

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

Ownership Listing-1

ID# 0001099

-Names of trust beneficiaries must be listed.

Management

1	Board of Directors						1
2	NH Committee ***						2
3							3
4	Kippy	Breeden		IL	BOD	N/A	4
5	Mark	Burton		IL	BOD	N/A	5
6	Shannon	Bumann		IL	BOD	N/A	6
7	Bob	Wachtel ***		IL	BOD	N/A	7
8	Jill	Darin		IL	BOD	N/A	8
9	Dave	Dobbels ***		IL	BOD	N/A	9
10	Joseph	Garrity		IL	BOD	N/A	10
11	Natalie	Hendryx		IL	BOD	N/A	11
12	Marshall	Jones		IL	BOD	N/A	12
13	Rex	Kiser		IL	BOD	N/A	13
14	Crystal	Strode		IL	BOD	N/A	14
15	Jan	May ***		IL	BOD	N/A	15
16	Ray	Elliott		IL	BOD	N/A	16
17	Kathy	Nelson ***		IL	BOD	N/A	17
18	Lynn	Sutton		IL	BOD	N/A	18
19	Tim	Yager		IL	BOD	N/A	19
20	James	Thompson		IL	BOD	N/A	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							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							67
68							68
69							69
70							70
71							71
72							72
73							73
74							74
75							75

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									\$		1
2	N/A										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Hillcrest Home # 0001099 Report Period Beginning: 12/01/24 Ending: 11/30/25

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							\$				\$	1
2	N/A											2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$				\$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$				\$	14
15	TOTALS (line 9+line14)						\$				\$	15

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

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

** 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 2024 report.		\$		1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$		2	
3. Under or (over) accrual (line 2 minus line 1).		\$		3	
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)		\$		4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$		7	
Assessed Value from Real Estate Tax Bill: 2024			8		
Real Estate Tax Bill for Calendar Year: 2020			9		
			10		
			11		
			12		
			13		
N/A - Hillcrest Home is exempt from real estate taxes.				14	FOR BHF USE ONLY
				14	FROM R. E. TAX STATEMENT FOR 2024 \$
				15	PLUS APPEAL COST FROM LINE 5 \$
				16	LESS REFUND FROM LINE 6 \$
				17	AMOUNT TO USE FOR RATE CALCULATION \$

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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Hillcrest Home COUNTY Henry
FACILITY IDPH LICENSE NUMBER 0001099
CONTACT PERSON REGARDING THIS REPORT Jeremy M. Brune, CPA
TELEPHONE (779) 875 - 3979 FAX #: (866) 216 - 5355

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 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 2024.

	(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>N/A</u>	<u></u>	\$ <u></u>	\$ <u></u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u></u>	\$ <u></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 copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

69,394

B. General Construction Type:

Exterior

Brick Masonry

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).

F. List the bed capacity for the building if it differs from the licensed total.

N/A

G. Have you properly capitalized all major repairs and equipment purchases?

Yes

H. Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A

I. Are you presently operating under a sublease agreement?

No

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

YES

NO

☒

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

Facility

K. 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			\$295,782	1
2					2
3	TOTALS			\$295,782	3

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	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	99		1972	1972	\$ 14,843	\$ 297		\$ 297		\$ 10,390
5			1976	1976	1,470,399	21,285		21,285		1,465,579
6										
7										
8										
	Improvement Type**									
9	Various		1975		6,984					6,984
10	Various		1977		587,919	11,758		11,758		525,980
11	Various		1980		14,609	292		292		13,294
12	Various		1981		61,074	1,221		1,221		54,353
13	Various		1983		58,988	930		930		52,016
14	Various		1984		42,387	848		848		35,183
15	Various		1985		37,751	755		755		33,975
16	Various		1986		14,176					14,176
17	Various		1987		106,332					106,332
18	Various		1988		7,056					7,056
19	Various		1989		52,914					52,914
20	Various		1990		702,566					702,566
21	Various		1991		307,262					307,262
22	Various		1992		4,763					4,763
23	Various		1993		18,731					18,731
24	Various		1994		7,853					7,853
25	Various		1995		54,348					54,348
26	Various		1996		3,119					3,119
27	Various		1997		70,766	383		383		67,881
28	Various		1998		373,421					373,421
29	Various		1999		49,155					49,155
30	Various		2000		7,401					7,401
31	Various		2001		36,455					36,455
32	Various		2002		36,275					36,275
33	Various		2003		5,347					5,347
34	Various		2004		55,195					55,195
35	Various		2005		59,348					59,348
36										

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Various	2006	\$ 72,627	\$		\$	\$	\$ 72,627	37
38	Various	2007	604,580					604,580	38
39	Various	2008	110,708					110,708	39
40	Various	2009	59,957					59,957	40
41	Various	2010	143,164					143,164	41
42	Various	2011	54,682					54,682	42
43	Various	2012	1,186,682	23,734		23,734		314,473	43
44	Various	2013	110,943	7,553		7,553		110,943	44
45	Various	2014	35,205					35,205	45
46	Various	2015	653,984	24,733		24,733		384,456	46
47	Various	2016	251,805	25,181		25,181		236,186	47
48	Various	2017	74,525	7,453		7,453		61,366	48
49	Various	2019	1,386,411	32,689		32,689		218,506	49
50	Various	2020	357,265	10,801		10,801		55,960	50
51	Various	2021	38,548	1,853		1,853		8,649	51
52	Door Replacement	2022	3,241	648		648		1,945	52
53	RFT Project - Call Light System	2022	35,128	7,026		7,026		21,077	53
54	Hot Water Heater Replacement	2022	12,900	1,290		1,290		5,160	54
55	Generator	2023	11,397	1,140		1,140		3,419	55
56	Hot Water Heater	2023	25,815	2,582		2,582		7,745	56
57	Window Replacement	2023	66,445	2,658		2,658		7,973	57
58	Pavilion	2023	31,400	1,256		1,256		3,768	58
59	Air Conditioner	2023	24,175	2,418		2,418		7,253	59
60	Building - Water Tanks	2024	157,822	3,156		3,156		3,156	60
61	Generator	2024	61,470	6,147		6,147		6,147	61
62	Garage	2024	138,414	5,537		5,537		5,537	62
63	Parking Lot	2024	145,778	9,719		9,719		9,719	63
64	Grease Trap	2024	33,589	3,359		3,359		3,359	64
65	Courtyard Garden	2024	32,502	3,250		3,250		3,250	65
66	Door - Knob and Lock Replacements	2025	18,524	1,472		1,472		1,472	66
67	Door - Touchpad Exit Controls	2025	2,118	35		35		35	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 10,209,241	\$ 223,459		\$ 223,459	\$	\$ 6,729,829	70

**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	\$726,645	\$47,200	\$47,200	\$		\$503,278	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Disposals							74
75	TOTALS	\$726,645	\$47,200	\$47,200	\$		\$503,278	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	Various	Various	\$321,961	\$11,838	\$11,838	\$		\$238,293	76
77										77
78										78
79										79
80	TOTALS			\$321,961	\$11,838	\$11,838	\$		\$238,293	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)	\$11,553,629	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$282,497	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$282,497	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$7,471,400	85

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

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

G. Construction-in-Progress

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

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

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

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.

YESNO

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

**

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

9. Option to Buy:

YESNO

Terms:

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

15. Is Movable equipment rental included in building rental?

YESNO
16. Rental Amount for movable equipment: \$0Description:

See Supplemental 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			\$	\$	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.	/2026	\$
13.	/2027	\$
14.	/2028	\$

* 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.

Description		Amount		Total
Building Rental				
				-
N/A				-
		-		-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
Total		-	-	
Equipment Rental				
				-
N/A				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
Total		-	-	

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 - 01	hrs	\$ 105,835		\$	\$		\$ 105,835	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			27,770			27,770	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	116,752					116,752	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 prescripts				36,514		36,514	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					2,753		2,753	12
13	Other (specify): See Supplemental	39 - 03				7,018			7,018	13
14	TOTAL			\$ 222,587		\$ 34,788	\$ 39,267		\$ 296,642	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Hillcrest Home Medicaid Cost Report 12/01/24 - 11/30/25

Page 16 Supplemental Schedule

[illegible]

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	\$ 1,686,843	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 75,000)	374,033		3
4	Supply Inventory (priced at FIFO - Cost)	21,617		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule	4,203		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,086,696	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	295,782		13
14	Buildings, at Historical Cost	10,120,855		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,121,430		16
17	Accumulated Depreciation (book methods)	(7,471,400)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule	64,725		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,131,392	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,218,088	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 116,745	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	250,215		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 366,960	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 366,960	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 5,851,128	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,218,088	\$	48

*(See instructions.)

Description		Operating		Building		Total
Line 9 - Other Current Assets						
Accrued Interest		4,203				4,203
						-
						-
						-
						-
Sub-Total		4,203		-		4,203
Line 23 - Long Term Assets						
Construction in Progress		12,500				12,500
Net Pension Reconciliation		52,225				52,225
						-
						-
						-
Sub-Total		64,725		-		64,725
Line 36 - Other Current Liability						
						-
						-
						-
						-
						-
Sub-Total		-		-		-
Line 43 - Long term Liabilities						
						-
						-
						-
						-
						-
Sub-Total		-		-		-

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,881,561	1
2	Restatements (describe):		2
3	Rounding	(2)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,881,559	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,030,431)	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)	\$ (1,030,431)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 5,851,128	24

*

* This must agree with page 17, line 47.

Facility Name & ID Number Hillcrest Home

0001099

Report Period Beginning:

12/01/24

Ending:

11/30/25

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	\$ 4,904,636	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,904,636	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	57,161	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 57,161	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,792	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,193	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 4,985	23
	D. Non-Operating Revenue		
24	Contributions	59,086	24
25	Interest and Other Investment Income***	35,736	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 94,822	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	823,586	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 823,586	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,885,190	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,443,051	31
32	Health Care	2,812,961	32
33	General Administration	1,953,294	33
	B. Capital Expense		
34	Ownership	282,497	34
	C. Ancillary Expense		
35	Special Cost Centers	296,642	35
36	Provider Participation Fee	127,176	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,915,621	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,030,431)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,030,431)	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$ 524,763	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	1,267,973	45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	2,320,835	48
49	Medicare Part A	334,004	49
50	Other-(specify) <u>Insurance</u>	199,061	50
51	Other-(specify) <u>Veterans</u>	61,049	51
52	Other-(specify) <u>Hospice</u>	196,951	52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,904,636	56

Hillcrest Home Medicaid Cost Report 12/01/24 - 11/30/25

Page 19 Supplemental Schedule

[illegible]

Facility Name & ID Number Hillcrest Home# 0001099

Report Period Beginning:

12/01/24

Ending:

11/30/25

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,997	2,080	\$ 85,632	\$ 41.17	1
2	Assistant Director of Nursing	288	341	13,356	39.17	2
3	Registered Nurses	7,920	8,772	307,014	35.00	3
4	Licensed Practical Nurses	17,752	20,119	607,163	30.18	4
5	CNAs & Orderlies	28,993	33,015	703,922	21.32	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,477	5,164	93,234	18.05	10
11	Social Service Workers	1,736	2,080	64,021	30.78	11
12	Dietician					12
13	Food Service Supervisor	1,840	2,080	70,871	34.07	13
14	Head Cook					14
15	Cook Helpers/Assistants	25,162	28,475	509,151	17.88	15
16	Dishwashers					16
17	Maintenance Workers	5,919	6,605	153,761	23.28	17
18	Housekeepers	8,521	9,587	155,619	16.23	18
19	Laundry	3,770	4,320	78,676	18.21	19
20	Administrator	1,463	1,760	86,198	48.98	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,909	8,784	215,604	24.55	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,805	3,412	83,507	24.47	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Suppl.</u>	5,336	5,811	222,587	38.30	33
34	TOTAL (lines 1 - 33)	125,888	142,405	\$ 3,450,316 *	\$ 24.23	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		\$ 5,779	01 - 03	35
36	Medical Director		11,000	09 - 03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,155	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		1,250	12 - 03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 22,184		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 145,137	10 - 03	50
51	Licensed Practical Nurses		119,434	10 - 03	51
52	Certified Nurse Assistants/Aides		463,693	10 - 03	52
53	TOTAL (lines 50 - 52)		\$ 728,264		53

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

** See instructions.

Hillcrest Home
Medicaid Cost Report
12/01/24 - 11/30/25

Page 20 Supplemental Schedule

Description	CC Reference	Hours Worked	Hours Paid	Salary	Average Rate	Hours Paid	Contracted Cost
Nursing Home Employees							
Physical Therapy	39	3,464	3,731	116,752	31.29		
Occupational Therapy	39	1,872	2,080	105,835	50.88		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
Total		5,336	5,811	222,587			

Contracted Services

Total			-	-

STATE OF ILLINOIS

Facility Name & ID NumberHillcrest Home# 0001099Report Period Beginning: 12/01/24Ending: 11/30/25Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Robin Barnes (12/01/24 - 04/15/25)	Administrator	0	\$ 39,253
Kevin Powell (06/15-25 - 11/30/25)	Administrator	0	46,945
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 86,198

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Jeremy Brune & Assoc, LLC	Cost Reports	\$ 4,050
The Stewart Law Firm, PC	Legal	1,956
PPMS, Inc.	Accounting	4,000
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 10,006

D. Employee Benefits and Payroll Taxes

Description	Amount	
Workers' Compensation Insurance	\$ 49,397	
Unemployment Compensation Insurance	1,596	
FICA Taxes	256,713	
Employee Health Insurance	251,262	
Employee Meals		
Illinois Municipal Retirement Fund (IMRF)*	695,516	
Other Benefits	98,830	
TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,353,314

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	4,080	
Health Care Worker Background Check (Indicate # of checks performed)	4,281	
Patient Background Checks		
Association Dues (total from pg 22, #4)		
Dues and Suscriptions	2,074	
Licenses and Permits	1,667	
Advertising	60	
Less: Public Relations Expense	()	
PAC and Lobbying payments	()	
All non-allowable advertising	(60)	
TOTAL (agree to Sch. V, line 20, col. 8)		\$ 12,102

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	1,693
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 1,693

* Attach copy of IMRF notifications

**See instructions.

Hillcrest Home Medicaid Cost Report 12/01/24 - 11/30/25

Page 21 Supplemental Schedule - Legal Invoice Detail

Vendor	Service Description	Invoice Date		Amount	Non-Allowable	Allowable
Stewart Law Firm, P.C.	General Counsel / Employee Relations	01/31/25		1,544		1,544
Stewart Law Firm, P.C.	General Counsel / Employee Relations	11/30/25		413		413
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	
					-	

Facility Name & ID Number Hillcrest Home

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.
- | Association Name | Amount |
|------------------|--------------|
| | |
| | |
| | |
| | Total |
- (3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.
- | | |
|--|--------------|
| | |
| | |
| | |
| | |
| | Total |
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)
- | | |
|--|--------------|
| | |
| | |
| | |
| | |
| | Total |
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. \$ 12,908 Line 10 - 02
- (6) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 127,176
This amount is to be recorded on line 42 of Schedule V.
- (8) 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.

- (9) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (10) 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.
- (11) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,792
- (12) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? Ln. 14
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (13) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Lauterbach & Amen, LLP (Not Final)
- (14) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes
- (15) 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. N/A
Attach invoices and a summary of services for all architect and appraisal fees.