FOR BHF USE

LL1

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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: 0051441

Facility Name: Hilltop Skilled Nsg & Rehab

Address: 910 West Polk Street (Number) Charleston (City) 61920 (Zip Code)

County: Coles

Telephone Number: (217)345-7066 **Fax #** (217)345-6017

HFS ID Number:

Date of Initial License for Current Owners: 5/1/2011

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Carol Sparks **Telephone Number:** (949)349-1222
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 01/01/17 to 12/31/17 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) (Date)
(Print Name and Title) Chris Joos, Partner
(Firm Name & Address) Plante & Moran, PLLC, 250 S. High Street, Suite 100
(Telephone) (614)222-9040 Fax # (248)233-8811

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 Hilltop Skilled Nsg & Rehab # 0051441 Report Period Beginning: 01/01/17 Ending: 12/31/17

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	36.00	Skilled (SNF)	36	13,140	1
2		Skilled Pediatric (SNF/PED)			2
3	72.00	Intermediate (ICF)	72	26,280	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	108	TOTALS	108	39,420	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,266	1,131	3,183	5,580	8
9	SNF/PED					9
10	ICF	5,770	4,662	368	10,800	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,036	5,793	3,551	16,380	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 41.55%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/01/2011

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/01/2011 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 25 and days of care provided 2,591

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Hilltop Skilled Nsg & Rehab # 0051441 Report Period Beginning: 01/01/17 Ending: 12/31/17

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	100,864	7,576	8,708	117,148	0	117,148	0	117,148			1
2	Food Purchase		79,429		79,429	0	79,429	0	79,429			2
3	Housekeeping	36,602	9,793	1,620	48,015	0	48,015	0	48,015			3
4	Laundry	21,461	2,943	55	24,459	0	24,459	0	24,459			4
5	Heat and Other Utilities			66,292	66,292	0	66,292	0	66,292			5
6	Maintenance	55,156	6,175	26,437	87,768	0	87,768	0	87,768			6
7	Other (specify):*	0	0	0	0	0	0	0	0			7
8	**TOTAL General Services**	214,083	105,916	103,112	423,111	0	423,111	0	423,111			8
	B. Health Care and Programs											
9	Medical Director	0	0	24,000	24,000	0	24,000	0	24,000			9
10	Nursing and Medical Records	882,897	45,675	7,806	936,378	0	936,378	(4,223)	932,155			10
10a	Therapy	0	0	340,712	340,712	0	340,712	(12,914)	327,798			10a
11	Activities	23,258	1,058	3,496	27,812	0	27,812	0	27,812			11
12	Social Services	37,906	0	2,236	40,142	0	40,142	0	40,142			12
13	CNA Training	0	0	0	0	0	0	0	0			13
14	Program Transportation	0	0	4,532	4,532	0	4,532	0	4,532			14
15	Other (specify):*	0	0	0	0	0	0	16,728	16,728			15
16	**TOTAL Health Care and Programs**	944,061	46,733	382,782	1,373,576	0	1,373,576	(409)	1,373,167			16
	C. General Administration											
17	Administrative	72,496	0	167,282	239,778	0	239,778	11,410	251,188			17
18	Directors Fees			0	0	0	0	0	0			18
19	Professional Services			57,595	57,595	0	57,595	(3,642)	53,953			19
20	Dues, Fees, Subscriptions & Promotions			9,558	9,558	0	9,558	(1,473)	8,085			20
21	Clerical & General Office Expenses	42,903	29,356	105,654	177,913	0	177,913	(80,826)	97,087			21
22	Employee Benefits & Payroll Taxes			292,346	292,346	0	292,346	(8,834)	283,512			22
23	Inservice Training & Education			0	0	0	0	0	0			23
24	Travel and Seminar			1,132	1,132	0	1,132	0	1,132			24
25	Other Admin. Staff Transportation		0	165	165	0	165	0	165			25
26	Insurance-Prop.Liab.Malpractice			230,835	230,835	0	230,835	0	230,835			26
27	Other (specify):*	39,683	0	19,989	59,672	0	59,672	(50,635)	9,037			27
28	**TOTAL General Administration**	155,082	29,356	884,556	1,068,994	0	1,068,994	(134,000)	934,994			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,313,226	182,005	1,370,450	2,865,681	0	2,865,681	(134,409)	2,731,272			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Hilltop Skilled Nsg & Rehab #0051441 Report Period Beginning: 01/01/17 Ending: 12/31/17

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			132,442	132,442	0	132,442	115,280	247,722			30
31	Amortization of Pre-Op. & Org.			0	0	0	0	0	0			31
32	Interest			0	0	0	0	28,379	28,379			32
33	Real Estate Taxes			41,809	41,809	0	41,809	(5,066)	36,743			33
34	Rent-Facility & Grounds			152,818	152,818	0	152,818	(152,818)	0			34
35	Rent-Equipment & Vehicles			32,213	32,213	0	32,213	0	32,213			35
36	Other (specify):*			109	109	0	109	(109)	0			36
37	**TOTAL Ownership**			359,391	359,391	0	359,391	(14,334)	345,057			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0			38
39	Ancillary Service Centers	0	4,660	138,843	143,503	0	143,503	0	143,503			39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0			40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0			41
42	Provider Participation Fee	0	0	140,595	140,595	0	140,595	0	140,595			42
43	Other (specify):*	0	0	0	0	0	0	0	0			43
44	**TOTAL Special Cost Centers**	0	4,660	279,438	284,098	0	284,098	0	284,098			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,313,226	186,665	2,009,279	3,509,170	0	3,509,170	(148,743)	3,360,427			45

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

Facility Name & ID Number Hilltop Skilled Nsg & Rehab # 0051441 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 0		$	1
2	Other Care for Outpatients	0			2
3	Governmental Sponsored Special Programs	0			3
4	Non-Patient Meals	0			4
5	Telephone, TV & Radio in Resident Rooms	0			5
6	Rented Facility Space	0			6
7	Sale of Supplies to Non-Patients	0			7
8	Laundry for Non-Patients	0			8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,290)	32		10
11	Discounts, Allowances, Rebates & Refunds	0			11
12	Non-Working Officer's or Owner's Salary	0			12
13	Sales Tax	0			13
14	Non-Care Related Interest	0			14
15	Non-Care Related Owner's Transactions	0			15
16	Personal Expenses (Including Transportation)	0			16
17	Non-Care Related Fees	0			17
18	Fines and Penalties	0			18
19	Entertainment	0			19
20	Contributions	0			20
21	Owner or Key-Man Insurance	0			21
22	Special Legal Fees & Legal Retainers	0			22
23	Malpractice Insurance for Individuals	0			23
24	Bad Debt	(63,932)	21		24
25	Fund Raising, Advertising and Promotional	(50,635)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax	0			26
27	CNA Training for Non-Employees	0			27
28	Yellow Page Advertising	0			28
29	Other-Attach Schedule	(40,242)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (156,099)		$ 0	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*	$ 0	0	31
32	Donated Goods-Attach Schedule*	0	0	32
33	Amortization of Organization & Pre-Operating Expense	0	0	33
34	Adjustments for Related Organization Costs (Schedule VII)	(157,965)	VII-B	34
35	Other- Attach Schedule	0		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (157,965)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (314,064)		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

Hilltop Skilled Nsg & Rehab

ID# 0051441

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Independent Living	$ 0	43	1
2	Non-Allowable Benefits (Marketing & ILU)	(8,834)	22	2
3	Bank Charges	(6,481)	21	3
4	Business Tax	(109)	36	4
5	Patient Theft or Loss	(65)	21	5
6	Prior Year Expense	(1,461)	21	6
7	Personal Items	(4,223)	10	7
8	Collection Agency Fees	(8,887)	21	8
9	Non-Allowable Dues	(1,473)	20	9
10	Non allowable adjustment	(3,642)	19	10
11	Non Allowable Real Estate Taxes	(5,066)	33	11
12		0		12
13		0		13
14		0		14
15		0		15
16		0		16
17		0		17
18		0		18
19		0		19
20		0		20
21		0		21
22		0		22
23		0		23
24		0		24
25		0		25
26		0		26
27		0		27
28		0		28
29		0		29
30		0		30
31		0		31
32		0		32
33		0		33
34		0		34
35		0		35
36		0		36
37		0		37
38		0		38
39		0		39
40		0		40
41		0		41
42		0		42
43		0		43
44		0		44
45		0		45
46		0		46
47		0		47
48		0		48
49	**Total**	(40,241)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hilltop Skilled Nsg & Rehab **#** 0051441 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(4,223)	0	0	0	0	0	0	0	0	0	0	(4,223)	10
10a	Therapy	0	0	(12,914)	0	0	0	0	0	0	0	0	(12,914)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	16,728	0	0	0	0	0	0	0	16,728	15
16	**TOTAL Health Care and Programs**	(4,223)	0	(12,914)	16,728	0	0	0	0	0	0	0	(409)	16
	C. General Administration													
17	Administrative	0	0	0	11,410	0	0	0	0	0	0	0	11,410	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,642)	0	0	0	0	0	0	0	0	0	0	(3,642)	19
20	Fees, Subscriptions & Promotions	(1,473)	0	0	0	0	0	0	0	0	0	0	(1,473)	20
21	Clerical & General Office Expenses	(80,826)	0	0	0	0	0	0	0	0	0	0	(80,826)	21
22	Employee Benefits & Payroll Taxes	(8,834)	0	0	0	0	0	0	0	0	0	0	(8,834)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):* **Marketing**	(50,635)	0	0	0	0	0	0	0	0	0	0	(50,635)	27
28	**TOTAL General Administration**	(145,410)	0	0	11,410	0	0	0	0	0	0	0	(134,000)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(149,633)	0	(12,914)	28,138	0	0	0	0	0	0	0	(134,409)	29

Facility Name & ID Number Hilltop Skilled Nsg & Rehab # 0051441 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	98,414	0	16,866	0	0	0	0	0	0	0	115,280	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,290)	0	0	29,669	0	0	0	0	0	0	0	28,379	32
33	Real Estate Taxes	(5,066)	0	0	0	0	0	0	0	0	0	0	(5,066)	33
34	Rent-Facility & Grounds	0	(152,818)	0	0	0	0	0	0	0	0	0	(152,818)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):* **Business Tax**	(109)	0	0	0	0	0	0	0	0	0	0	(109)	36
37	**TOTAL Ownership**	(6,465)	(54,404)	0	46,535	0	0	0	0	0	0	0	(14,334)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(156,098)	(54,404)	(12,914)	74,673	0	0	0	0	0	0	0	(148,743)	45

Facility Name & ID Number Hilltop Skilled Nsg & Rehab # 0051441 Report Period Beginning: 01/01/17 Ending: 12/31/17

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. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		34	Rent	$ 152,818	CC Charleston, LLC	100.00%	$	$ (152,818)	1
2	V		30	Depreciation		CC Charleston, LLC	100.00%	98,414	98,414	2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 152,818			$ 98,414	$ * (54,404)	14

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

Facility Name & ID Number Hilltop Skilled Nsg & Rehab # 0051441 Report Period Beginning: 01/01/17 Ending: 12/31/17

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. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10a	Physical Therapy	$ 211,894	Affirma Rehabilitation	100.00%	$ 203,863	$ (8,031)	15
16	V	10a	Occupational Therapy	106,209	Affirma Rehabilitation	100.00%	102,184	(4,025)	16
17	V	10a	Speech Therapy	22,608	Affirma Rehabilitation	100.00%	21,751	(857)	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			$ 340,712			$ 327,798	$ * (12,914)	39

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

Facility Name & ID Number Hilltop Skilled Nsg & Rehab # 0051441 Report Period Beginning: 01/01/17 Ending: 12/31/17

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. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	15	Direct	$	Covenant Care California, LLC	100.00%	$ 16,728	$ 16,728	15
16	V	17	Indirect		Covenant Care California, LLC	100.00%	178,692	178,692	16
17	V	32	Interest		Covenant Care California, LLC	100.00%	29,669	29,669	17
18	V	30	Depreciation		Covenant Care California, LLC	100.00%	16,866	16,866	18
19	V	17	Management Fee	167,282	Covenant Care California, LLC	100.00%		(167,282)	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			$ 167,282			$ 241,955	$ * 74,673	39

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

Facility Name & ID Number Hilltop Skilled Nsg & Rehab # 0051441 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	COVENANT CARE CALIFORNIA, LLC	100.00%	ARBOR NURSING CENTER	CALIFORNIA	COVENANT CARE C	ALISO VIEJO, CA	MANAGEMENT C	1
2			ARBOR PLACE	CALIFORNIA	AFFIRMA REHABIL	ALISO VIEJO, CA	THERAPY	2
3			BUENA VISTA CARE CENTER, A NURSING	CALIFORNIA	CC CHARLESTON, L	CHARLESTON, IL	BUILDING CO.	3
4			CARSON NURSING & REHAB CENTER	NEVADA				4
5			CATERED MANOR	CALIFORNIA				5
6			CLINTON HOUSE HEALTH & REHABILITA	INDIANA				6
7			COURTYARD HEALTHCARE CENTER	CALIFORNIA				7
8			COVENANT CARE HILLTOP, LLC D/B/A HI	CHARLESTON				8
9			COVENANT CARE JACKSONVILLE, LLC D/	JACKSONVILLE				9
10			COVENANT CARE MEADOW MANOR, LLC	TAYLORVILLE				10
11			COVENANT CARE MIDWEST, INC. D/B/A C	LEBANON				11
12			COVENANT CARE SUNRISE, LLC D/B/A SU	VIRDEN				12
13			COVINGTON MANOR	INDIANA				13
14			DOWNEY CARE	CALIFORNIA				14
15			EAGLE POINT NURSING & REHAB CENTE	IOWA				15
16			EDGEWOOD MANOR NURSING CENTER	OHIO				16
17			EMERALD GARDENS NURSING CENTER	CALIFORNIA				17
18			ENCINITAS NURSING AND REHABILITATI	CALIFORNIA				18
19			ENNOBLE SKILLED NURSING & REHAB CE	IOWA				19
20			FAIRVIEW MANOR NURSING CENTER	OHIO				20
21			FRIENDSHIP HOME	CARLINVILLE, IL				21
22			GILROY HEALTHCARE & REHABILITATIC	CALIFORNIA				22
23			GRANT CUESTA NURSING & REHABILITA	CALIFORNIA				23
24			HIGHLAND HEALTH CARE CENTER	ILLINOIS				24
25			HUNTINGTON PARK NURSING CENTER	CALIFORNIA				25
26			LA JOLLA NURSING AND REHABILITATIO	CALIFORNIA				26
27			LAKELAND NURSING CENTER	INDIANA				27
28			LOS ALTOS SUB-ACUTE & REHABILITATI	CALIFORNIA				28
29			MISSION SKILLED NURSING & SUBACUTE	CALIFORNIA				29
30			NEBRASKA SKILLED NURSING CENTER	NEBRASKA				30

Facility Name & ID Number Hilltop Skilled Nsg & Rehab # 0051441 Report Period Beginning: 01/01/17 Ending: 12/31/17

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			NORWOOD NURSING CENTER	INDIANA				1
2			PACIFIC COAST MANOR	CALIFORNIA				2
3			PACIFIC GARDENS NURSING & REHABILI	CALIFORNIA				3
4			PACIFIC HILLS MANOR	CALIFORNIA				4
5			PALO ALTO NURSING CENTER	CALIFORNIA				5
6			ROYAL CARE SKILLED NURSING CENTER	CALIFORNIA				6
7			SHORELINE CARE CENTER	CALIFORNIA				7
8			SILVER HILLS HEALTH CARE CENTER	NEVADA				8
9			SILVER RIDGE HEALTHCARE CENTER	NEVADA				9
10			ST. EDNA SUBACUTE & REHABILITATION	CALIFORNIA				10
11			THE RESIDENCE AT MCCORMICK'S CREE	INDIANA				11
12			TURLOCK NURSING AND REHABILITATIO	CALIFORNIA				12
13			TURLOCK RESIDENTIAL	CALIFORNIA				13
14			UNIVERSITY PARK NURSING CENTER	INDIANA				14
15			VALLE VISTA CONVALESCENT CENTER	CALIFORNIA				15
16			VERSAILLES HEALTH CARE CENTER	OHIO				16
17			VILLA GEORGETOWN	OHIO				17
18			VILLA SPRINGFIELD	OHIO				18
19			VINTAGE FAIRE NURSING & REHABILITA	CALIFORNIA				19
20			VINTAGE FAIRE RESIDENTIAL	CALIFORNIA				20
21			WAGNER HEIGHTS NURSING & REHABILI	CALIFORNIA				21
22			WAGNER HEIGHTS RESIDENTIAL	CALIFORNIA				22
23			WALDRON HEALTH AND REHAB CENTER	INDIANA				23
24			WILLOW TREE NURSING & REHABILITAT	CALIFORNIA				24
25			WRIGHT NURSING & REHAB CENTER (VII	OHIO				25
26			MARION REHAB AND ASSISTED LIVING C	INDIANA				26
27			PYRAMID POINT POST ACUTE REHABILIT	INDIANA				27
28								28
29								29
30								30

Facility Name & ID Number Hilltop Skilled Nsg & Rehab # 0051441 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											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 Hilltop Skilled Nsg & Rehab # 0051441 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Hilltop Skilled Nsg & Rehab # 0051441 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 [X] NO [ ]

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

Name of Related Organization: Affirma Rehabilitation
Street Address: 27071 Aliso Creek Road
City / State / Zip Code: Aliso Viejo, CA 92656
Phone Number: (888)468-4372
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Physical Therapy	Direct Allocation			$	$		$ 218,135	1
2	39	Occupational Therapy	Direct Allocation						101,064	2
3	39	Speech Therapy	Direct Allocation						21,513	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					$	$		$ 340,712	25

Facility Name & ID Number Hilltop Skilled Nsg & Rehab # 0051441 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 [X] NO [ ]

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

Name of Related Organization: Covenant Care California, LLC
Street Address: 27071 Aliso Creek Road
City / State / Zip Code: Aliso Viejo, CA 92656
Phone Number: (949)349-1200
Fax Number: (949)349-1900

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	43	NonAllow	Accumulated Cost			$	$		$ 0	1
2	15	Direct	Accumulated Cost						16,728	2
3	17	Indirect	Accumulated Cost						178,692	3
4	32	Interest	Accumulated Cost						29,669	4
5	30	Depreciation	Accumulated Cost						16,866	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					$	$		$ 241,955	25

Facility Name & ID Number Hilltop Skilled Nsg & Rehab # 0051441 Report Period Beginning: 01/01/17 Ending: 12/31/17

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												2
3												3
4												4
5												5
	Working Capital											
6	Allocated from Covenant Care Inc.		X								30,959	6
7												7
8												8
9	TOTAL Facility Related						$ 0	$ 0			$ 30,959	9
	B. Non-Facility Related*											
10	Interest Income		X								(1,290)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ (1,290)	14
15	TOTALS (line 9+line14)						$ 0	$ 0			$ 29,669	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

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

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

Facility Name & ID Number Hilltop Skilled Nsg & Rehab # 0051441 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 36,743	2
3. Under or (over) accrual (line 2 minus line 1).		$ 36,743	3
4. Real Estate Tax accrual used for 2017 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		$ 36,743	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	33,931	8
	2013	33,258	9
	2014	31,063	10
	2015	36,361	11
	2016	36,743	12

Facility does not accrue real estate taxes

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Hilltop Skilled Nsg & Rehab COUNTY Coles

FACILITY IDPH LICENSE NUMBER 0051441

CONTACT PERSON REGARDING THIS REPORT Carol Sparks

TELEPHONE (949)349-1222 FAX #: (949) 349-1122

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-1-00706-00	Long Term Care Property	$ 36,743.36	$ 36,743.36
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 36,743.36	$ 36,743.36

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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

Facility Name & ID Number Hilltop Skilled Nsg & Rehab # 0051441 Report Period Beginning: 01/01/17 Ending: 12/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,709 B. General Construction Type: Exterior Masonry Frame Wood & Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO

If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$ 0	3

Facility Name & ID Number Hilltop Skilled Nsg & Rehab # 0051441 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	108		2015	1966	$ 885,730	$	35	$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2011	33,819		20				9
10	Various			2012	691,679		20				10
11	Various			2013	7,162		20				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

*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 Hilltop Skilled Nsg & Rehab # 0051441 Report Period Beginning: 01/01/17 Ending: 12/31/17

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			$	$		$	$	$	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)					29,524	29,524	73,811	67
68	Related Party Allocations (Pages 12H & 12I)					16,866	16,866		68
69	Financial Statement Depreciation					109,871	109,871	559,639	69
70	TOTAL (lines 4 thru 69)		$ 1,618,390	$ 0		$ 156,261	$ 156,261	$ 633,449	70

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

Facility Name & ID Number Hilltop Skilled Nsg & Rehab # 0051441 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,618,390	$ 0		$ 156,261	$ 156,261	$ 633,449	1
2	2 Ton A/C Unit	2013	4,162		20	208	208	1,040	2
3	Repair Roof	2013	3,000		20	150	150	750	3
4	5 Ton 3 Phase Condensor Ac Unit	2014	3,150		20	158	158	631	4
5	Booster Heater Water Heater	2016	2,543		20	254	254	508	5
6	Asphalt Paving, Sidewalk Replacement, Roofing, Plumbing	2016	85,887		20	4,294	4,294	8,588	6
7	Garbage Disposal	2017	1,126		7	148	148	148	7
8	Wanderguard Report	2017	17,400		7	0		0	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)		$ 1,735,659	$ 0		$ 161,473	$ 161,473	$ 645,114	34

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

Facility Name & ID Number Hilltop Skilled Nsg & Rehab # 0051441 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 1,735,659	$ 0		$ 161,473	$ 161,473	$ 645,114	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)		$ 1,735,659	$ 0		$ 161,473	$ 161,473	$ 645,114	34

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

Facility Name & ID Number Hilltop Skilled Nsg & Rehab # 0051441 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 546,535	$	$ 85,740	$ 85,740	10	$ 349,699	71
72	Current Year Purchases				0			72
73	Fully Depreciated Assets	48,301			0		48,301	73
74					0			74
75	TOTALS	$ 594,837	$ 0	$ 85,740	$ 85,740		$ 398,000	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	Ford, Van, 2012	2017	$ 10,715	$	$ 510	$ 510	7	$ 510	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 10,715	$ 0	$ 510	$ 510		$ 510	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)	$ 2,341,210	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 0	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 247,722	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 247,722	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,043,624	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.

Company	Locn	Dept	Account	Journal_Des	Amount	Month	Year	JournalNum	ApplyDate
CCMIDWST	076	6200	60000620	ACE HARI	20	10	2017	JRNL0019	10/31/17
CCMIDWST	076	6200	60000620	ACE HARI	20	11	2017	JRNL0019	11/30/17
CCMIDWST	076	6200	60000620	ACE HARI	35	12	2017	JRNL0019	12/31/17
CCMIDWST	076	6200	60000620	FIVE STAI	111	5	2017	JRNL0018	05/31/17
CCMIDWST	076	6200	60000620	FIVE STAI	18	5	2017	JRNL0018	05/31/17
CCMIDWST	076	6200	60000620	FIVE STAI	111	11	2017	JRNL0019	11/30/17
CCMIDWST	076	6500	60000620	ECOLAB -	76	12	2017	JRNL0019	12/31/17
CCMIDWST	076	6500	60000620	ECOLAB -	76	11	2017	JRNL0019	11/30/17
CCMIDWST	076	6500	60000620	ECOLAB -	76	10	2017	JRNL0018	10/31/17
CCMIDWST	076	6500	60000620	ECOLAB -	74	9	2017	JRNL0018	09/30/17
CCMIDWST	076	6500	60000620	ECOLAB -	74	8	2017	JRNL0018	08/31/17
CCMIDWST	076	6500	60000620	ECOLAB -	74	7	2017	JRNL0018	07/31/17
CCMIDWST	076	6500	60000620	ECOLAB -	74	6	2017	JRNL0018	06/30/17
CCMIDWST	076	6500	60000620	ECOLAB -	74	5	2017	JRNL0018	05/31/17
CCMIDWST	076	6500	60000620	ECOLAB -	74	4	2017	JRNL0018	04/30/17
CCMIDWST	076	6500	60000620	ECOLAB -	74	3	2017	JRNL0018	03/31/17
CCMIDWST	076	6500	60000620	ECOLAB -	74	2	2017	JRNL0018	02/28/17
CCMIDWST	076	6500	60000620	ECOLAB -	74	1	2017	JRNL0018	01/31/17
CCMIDWST	076	6901	60000620	Rcl HP MF	108	9	2017	JRNL0018	09/30/17
CCMIDWST	076	6901	60000620	Rcl HP MF	108	10	2017	JRNL0019	10/31/17
CCMIDWST	076	6901	60000620	KONICA M	271	7	2017	JRNL0018	07/13/17
CCMIDWST	076	6901	60000620	KONICA M	271	6	2017	JRNL0018	06/01/17
CCMIDWST	076	6901	60000620	KONICA M	271	5	2017	JRNL0018	05/01/17
CCMIDWST	076	6901	60000620	KONICA M	271	4	2017	JRNL0018	04/03/17
CCMIDWST	076	6901	60000620	KONICA M	-	4	2017	JRNL0018	04/03/17
CCMIDWST	076	6901	60000620	KONICA M	271	3	2017	JRNL0018	03/14/17
CCMIDWST	076	6901	60000620	KONICA M	-	3	2017	JRNL0018	03/14/17
CCMIDWST	076	6901	60000620	KONICA M	271	2	2017	JRNL0018	02/11/17
CCMIDWST	076	6901	60000620	KONICA M	-	2	2017	JRNL0018	02/11/17
CCMIDWST	076	6901	60000620	KONICA M	271	1	2017	JRNL0018	01/18/17
CCMIDWST	076	6901	60000620	KONICA M	-	1	2017	JRNL0018	01/18/17
CCMIDWST	076	6901	60000620	HEWLETT	(100)	11	2017	JRNL0018	11/01/17
CCMIDWST	076	6901	60000620	HEWLETT	100	11	2017	JRNL0018	11/01/17
CCMIDWST	076	6901	60000620	GANO WE	245	9	2017	JRNL0018	09/21/17
CCMIDWST	076	6901	60000620	GANO WE	36	6	2017	JRNL0018	06/30/17
CCMIDWST	076	6901	60000620	GANO WE	242	4	2017	JRNL0018	04/30/17
CCMIDWST	076	6901	60000620	Amort Can	391	8	2017	JRNL0018	08/31/17
CCMIDWST	076	6901	60000620	Amort Can	391	7	2017	JRNL0018	07/31/17
CCMIDWST	076	8131	60000620	RECOVEF	294	1	2017	JRNL0018	01/31/17
CCMIDWST	076	8131	60000620	LINCOLNL	40	8	2017	JRNL0018	08/22/17
CCMIDWST	076	8131	60000620	LINCOLNL	150	8	2017	JRNL0018	08/22/17
CCMIDWST	076	8131	60000620	LINCOLNL	150	8	2017	JRNL0018	08/22/17
CCMIDWST	076	8131	60000620	LINCOLNL	150	8	2017	JRNL0018	08/22/17
CCMIDWST	076	8131	60000620	LINCOLNL	40	8	2017	JRNL0018	08/22/17
CCMIDWST	076	8131	60000620	LINCOLNL	40	8	2017	JRNL0018	08/22/17
CCMIDWST	076	8131	60000620	LINCOLNL	40	8	2017	JRNL0018	08/22/17
CCMIDWST	076	8131	60000620	LINCOLNL	40	6	2017	JRNL0018	06/30/17

CCMIDWST	076	8131	60000620	LINCOLNL	40	6	2017	JRNL0018	06/30/17
CCMIDWST	076	8131	60000620	LINCOLNL	150	5	2017	JRNL0018	05/31/17
CCMIDWST	076	8131	60000620	LINCOLNL	150	5	2017	JRNL0018	05/31/17
CCMIDWST	076	8131	60000620	LINCOLNL	150	5	2017	JRNL0018	05/31/17
CCMIDWST	076	8131	60000620	JOERNS L	171	8	2017	JRNL0018	08/21/17
CCMIDWST	076	8131	60000620	JOERNS L	50	6	2017	JRNL0018	06/30/17
CCMIDWST	076	8131	60000620	JOERNS L	(22)	4	2017	JRNL0018	04/18/17
CCMIDWST	076	8131	60000620	JOERNS L	44	4	2017	JRNL0018	04/18/17
CCMIDWST	076	8131	60000620	JOERNS L	(22)	4	2017	JRNL0018	04/18/17
CCMIDWST	076	8131	60000620	JOERNS L	44	4	2017	JRNL0018	04/18/17
CCMIDWST	076	8131	60000620	JOERNS L	588	2	2017	JRNL0018	02/28/17
CCMIDWST	076	8131	60000620	JOERNS L	154	2	2017	JRNL0018	02/28/17
CCMIDWST	076	8131	60000620	JOERNS L	72	2	2017	JRNL0018	02/28/17
CCMIDWST	076	8131	60000620	ISAVE - JC	165	12	2017	JRNL0019	12/11/17
CCMIDWST	076	8131	60000620	ISAVE - JC	99	11	2017	JRNL0019	11/13/17
CCMIDWST	076	8131	60000620	CR- Joern	(5)	11	2017	JRNL0019	11/30/17
CCMIDWST	076	8131	60000620	CR- Joern	(722)	12	2017	JRNL0019	12/31/17
CCMIDWST	076	8131	60000620	CR- Joern	(115)	12	2017	JRNL0019	12/31/17
CCMIDWST	076	8131	60000620	CARLE MI	234	11	2017	JRNL0019	11/30/17
CCMIDWST	076	8131	60000620	CARLE MI	312	10	2017	JRNL0018	10/31/17
CCMIDWST	076	8131	60000620	CARLE MI	494	4	2017	JRNL0018	04/30/17
CCMIDWST	076	8131	60000620	CARLE MI	468	4	2017	JRNL0018	04/13/17
CCMIDWST	076	8131	60000620	CARLE MI	104	3	2017	JRNL0018	03/31/17
CCMIDWST	076	8131	60000620	Acr exp St	(171)	8	2017	JRNL0018	08/31/17
CCMIDWST	076	8131	60000620	Acr exp St	171	7	2017	JRNL0018	07/31/17
CCMIDWST	076	8131	60000620	Acc 12/17	171	12	2017	JRNL0019	12/31/17
CCMIDWST	076	8131	60000620	Acc 11/17	(165)	12	2017	JRNL0019	12/31/17
CCMIDWST	076	8131	60000620	Acc 11/17	165	11	2017	JRNL0019	11/30/17
CCMIDWST	076	8131	60000620	Acc 10/17	(99)	11	2017	JRNL0019	11/30/17
CCMIDWST	076	8131	60000620	Acc 10/17	99	10	2017	JRNL0018	10/31/17
CCMIDWST	076	8200	60000620	ACCELER	982	12	2017	JRNL0019	12/25/17
CCMIDWST	076	8200	60000620	ACCELER	1,164	11	2017	JRNL0019	11/25/17
CCMIDWST	076	8200	60000620	ACCELER	1,477	10	2017	JRNL0018	10/25/17
CCMIDWST	076	8200	60000620	ACCELER	1,477	9	2017	JRNL0018	09/25/17
CCMIDWST	076	8200	60000620	ACCELER	1,477	8	2017	JRNL0018	08/25/17
CCMIDWST	076	8200	60000620	ACCELER	1,477	7	2017	JRNL0018	07/25/17
CCMIDWST	076	8200	60000620	ACCELER	1,477	6	2017	JRNL0018	06/25/17
CCMIDWST	076	8200	60000620	ACCELER	1,477	5	2017	JRNL0018	05/25/17
CCMIDWST	076	8200	60000620	ACCELER	1,477	4	2017	JRNL0018	04/25/17
CCMIDWST	076	8200	60000620	ACCELER	1,477	3	2017	JRNL0018	03/25/17
CCMIDWST	076	8200	60000620	ACCELER	1,477	2	2017	JRNL0018	02/25/17
CCMIDWST	076	8200	60000620	ACCELER	1,466	1	2017	JRNL0018	01/25/17
CCMIDWST	076	8200	60000620	ACCELER	11	1	2017	JRNL0018	01/27/17

Total 25,261

Facility Name & ID Number Hilltop Skilled Nsg & Rehab # 0051441 Report Period Beginning: 01/01/17 Ending: 12/31/17

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:				$ 152,818			3
4	Additions							4
5								5
6								6
7	TOTAL				$ 152,818 **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

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

	Fiscal Year Ending	Annual Rent
12.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 25,261 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Van	$ #######	$ 6,952	17
18					18
19					19
20					20
21	TOTAL		$ #######	$ 6,952	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Hilltop Skilled Nsg & Rehab # 0051441 Report Period Beginning: 01/01/17 Ending: 12/31/17

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	V10A	hrs	$	2,005	$ 102,184	$	2,005	$ 102,184	1
2	Licensed Speech and Language Development Therapist	V10A	hrs		511	21,751		511	21,751	2
3	Licensed Recreational Therapist	V10A	hrs							3
4	Licensed Physical Therapist	V10A	hrs		4,890	203,863		4,890	203,863	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	V39	hrs				745		745	8
9	Pharmacy	V39	# of prescrpts				121,388		121,388	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): LAB/RADIOLOGY	V39					9,879		9,879	12
13	Other (specify): BILLABLE SUPPLIES	V39					11,491		11,491	13
14	TOTAL			$	7,407	$ 327,798	$ 143,503	7,407	$ 471,301	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.

Facility Name & ID Number Hilltop Skilled Nsg & Rehab # 0051441 Report Period Beginning: 01/01/17 Ending: 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/17 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,000	$ 1,000	1
2	Cash-Patient Deposits	0		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 150,965)	347,165	347,165	3
4	Supply Inventory (priced at)	45,759	45,759	4
5	Short-Term Investments	0		5
6	Prepaid Insurance	0		6
7	Other Prepaid Expenses	2,156	2,159	7
8	Accounts Receivable (owners or related parties)	0		8
9	Other(specify):	8,954	8,954	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 405,034	$ 405,037	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	0		11
12	Long-Term Investments	0		12
13	Land	0		13
14	Buildings, at Historical Cost	0	885,730	14
15	Leasehold Improvements, at Historical Cos	849,928	849,928	15
16	Equipment, at Historical Cost	261,102	605,552	16
17	Accumulated Depreciation (book methods)	(797,588)	(1,043,624)	17
18	Deferred Charges	0		18
19	Organization & Pre-Operating Costs	0		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	0		20
21	Restricted Funds	0		21
22	Other Long-Term Assets (specify):	0		22
23	Other(specify): Medicare Cost Settlements	33,169	33,169	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 346,611	$ 1,330,755	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 751,645	$ 1,735,792	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 0	$	26
27	Officer's Accounts Payable	0		27
28	Accounts Payable-Patient Deposits	0		28
29	Short-Term Notes Payable	0		29
30	Accrued Salaries Payable	69,513	69,513	30
31	Accrued Taxes Payable (excluding real estate taxes)	0		31
32	Accrued Real Estate Taxes(Sch.IX-B)	0		32
33	Accrued Interest Payable	0		33
34	Deferred Compensation	0		34
35	Federal and State Income Taxes	0		35
	Other Current Liabilities(specify):			
36		0		36
37	Intercompany	2,120,190	3,048,133	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,189,703	$ 3,117,646	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	0		39
40	Mortgage Payable	0		40
41	Bonds Payable	0		41
42	Deferred Compensation	0		42
	Other Long-Term Liabilities(specify):			
43	QAF Fees / General Liability	33,811	33,811	43
44		0		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 33,811	$ 33,811	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,223,514	$ 3,151,457	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,471,869)	$ (1,415,665)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 751,645	$ 1,735,792	48

***(See instructions.)**

077-CC Charleston, LLC (#076)

For the Twelve Months Ending December 31, 2017

Acct Number	Dept	Account	Description	YTD	Acct #
077-0000-12210000	0000	12210000	BLDG & IMPV - FACILITY BUILDINGS	885,730.00	
077-0000-12410000	0000	12410000	EQUIP - MAJOR MOVABLE	344,450.00	
077-0000-12710000	0000	12710000	ACC DEPR - FACILITY BUILDINGS	(73,810.79)	
077-0000-12910000	0000	12910000	ACC DEPR - MAJOR MOVABLE EQUIP	(172,224.94)	
077-0000-20800099	0000	20800099	INTERCOMPANY	(927,943.89)	
077-0000-24400100	0000	24400100	EQUITY - RETAINED EARNINGS	(56,200.38)	
077-0000-29990000	0000	29990000	CURRENT YEAR PROFIT/LOSS	54,403.71	
077-7100-70009220	7100	70009220	PROPERTY DEPR-BLDGS & IMPROVEMEN	29,524.32	
077-7100-70009240	7100	70009240	PROPERTY DEPR-MAJOR MOVABLE EQUIF	68,889.97	
077-8000-40003430	8000	40003430	MISC. REV. RENT INCOME	(152,818.00)	

-

(????10000000 TO...	Total Assets	984,144.27
(????20900000 TO...	Total Liabilities - Continued	(1,796.67)
(????3??????? TO...	Total Profit/Loss	(54,403.71)

1

Facility Name & ID Number Hilltop Skilled Nsg & Rehab # 0051441 Report Period Beginning: 01/01/17 Ending: 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,295,955)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,295,955)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(175,914)	7
8	Aquisitions of Pooled Companies	0	8
9	Proceeds from Sale of Stock	0	9
10	Stock Options Exercised	0	10
11	Contributions and Grants	0	11
12	Expenditures for Specific Purposes	0	12
13	Dividends Paid or Other Distributions to Owners	(0)	13
14	Donated Property, Plant, and Equipment	0	14
15	Other (describe) 0	0	15
16	Other (describe) 0	0	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (175,914)	17
	B. Transfers (Itemize):		
18			18
19	0	0	19
20	0	0	20
21	0	0	21
22	0	0	22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,471,869)	24 *

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

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,485,526	1
2	Discounts and Allowances for all Levels	(548,098)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,937,428	3
	B. Ancillary Revenue		
4	Day Care	0	4
5	Other Care for Outpatients	0	5
6	Therapy	1,248,928	6
7	Oxygen	0	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,248,928	8
	C. Other Operating Revenue		
9	Payments for Education	0	9
10	Other Government Grants	0	10
11	CNA Training Reimbursements	0	11
12	Gift and Coffee Shop	0	12
13	Barber and Beauty Care	0	13
14	Non-Patient Meals	0	14
15	Telephone, Television and Radio	0	15
16	Rental of Facility Space	0	16
17	Sale of Drugs	118,319	17
18	Sale of Supplies to Non-Patients	0	18
19	Laboratory	4,729	19
20	Radiology and X-Ray	5,508	20
21	Other Medical Services	12,831	21
22	Laundry	0	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 141,387	23
	D. Non-Operating Revenue		
24	Contributions	0	24
25	Interest and Other Investment Income***	1,290	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,290	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)	0	27
28	AL/IL	0	28
28a	Misc Revenue	4,223	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,223	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,333,256	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	423,111	31
32	Health Care	1,373,576	32
33	General Administration	1,068,994	33
	B. Capital Expense		
34	Ownership	359,391	34
	C. Ancillary Expense		
35	Special Cost Centers	143,503	35
36	Provider Participation Fee	140,595	36
	D. Other Expenses (specify):		
37	0	0	37
38	0	0	38
39	0	0	39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,509,170	40
41	**Income before Income Taxes (line 30 minus line 40)****	(175,914)	41
42	**Income Taxes**	0	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (175,914)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 985,675	44
45	Private Pay - Net Inpatient Revenue	750,484	45
46	Medicare - Net Inpatient Revenue	1,290,943	46
47	Other-(specify) ALL OTHER SNF/SCF IP REVENUE	163,687	47
48	Other-(specify) C/A ANCILLARY ACCOUNTS	(1,253,362)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 1,937,428	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.**

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,859	1,965	$ 69,609	$ 35.42	1
2	Assistant Director of Nursing					2
3	Registered Nurses	677	1,000	61,716	61.72	3
4	Licensed Practical Nurses	16,937	16,937	414,117	24.45	4
5	CNAs & Orderlies	27,326	27,326	337,234	12.34	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,378	1,378	17,102	12.41	9
10	Activity Assistants	399	415	6,156	14.83	10
11	Social Service Workers	2,335	2,389	37,906	15.87	11
12	Dietician					12
13	Food Service Supervisor	1,928	1,928	32,776	17.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,712	6,773	68,088	10.05	15
16	Dishwashers					16
17	Maintenance Workers	1,888	1,888	55,156	29.21	17
18	Housekeepers	3,730	3,831	36,602	9.55	18
19	Laundry	2,323	2,350	21,461	9.13	19
20	Administrator	2,155	2,163	72,496	33.52	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,173	2,263	42,903	18.96	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)	8	8	221	27.63	32
33	Other(specify)	1,814	1,889	39,683	21.01	33
34	TOTAL (lines 1 - 33)	73,642	74,503	$ 1,313,226 *	$ 17.63	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	179	$ 8,708	01-03	35
36	Medical Director	13	24,000	09-03	36
37	Medical Records Consultant	16	2,040	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	26	3,111	11-03	44
45	Social Service Consultant	26	2,236	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	260	$ 40,094		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Emily Masulis	Administrator	0	$ 72,496
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 72,496

B. Administrative - Other

Description	Amount
Management Fees - Covenant Care California, LLC	$ 167,282
TOTAL (agree to Schedule V, line 17, col. 3)	$ 167,282
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal Fees	$ 112
Ability Network	Data Processing	620
Wescom Solutions Inc	Data Processing	44,080
National Datacare Corp	Data Processing	1,383
Pinnacle Quality Insight	Customer Satisfaction	2,175
Smartlinx Solutions	Workforce Management	3,902
Verify	Data Processing	4,112
Iron Mountain	Data Processing	1,210
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 57,595

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 59,930
Unemployment Compensation Insurance	
FICA Taxes	120,779
Employee Health Insurance	96,841
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Dental Insurance	25
Vision Insurance	(3)
Other Employee Benefits	3,842
Employee Physicals/X-Ray	235
Disability	1,863
TOTAL (agree to Schedule V, line 22, col.8)	$ 283,512

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	$ 2,005
Advertising: Employee Recruitment	1,536
Health Care Worker Background Check	
(Indicate # of checks performed)	
Dues & Subscriptions	4,144
Licenses & Permits	400
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,085

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,132
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,132

* Attach copy of IMRF notifications

**See instructions.

Company	Locn	Dept	Account	Journal_Des	Amount	Month	Year	JournalNum	ApplyDate	Purpose	check	invoice
CCMIDWS	076	6901	60000470	Acr Sandb	(1,077)	1	2017	JRNL0018	01/31/17	reclassified		
CCMIDWS	076	6901	60000470	Acr Sandb	1,077	1	2017	JRNL0018	01/31/17	reclassified		
CCMIDWS	076	6901	60000470	Acr Sandb	1,077	2	2017	JRNL0018	02/28/17	reclassified		
CCMIDWS	076	6901	60000470	Acr Sandb	(1,077)	2	2017	JRNL0018	02/28/17	reclassified		
CCMIDWS	076	6901	60000470	Rcl Sandb	1,077	3	2017	JRNL0018	03/31/17	reclassified		
CCMIDWS	076	6901	60000470	Acr Sandb	(1,077)	3	2017	JRNL0018	03/31/17	reclassified		
CCMIDWS	076	6901	60000470	SANDBER	112	11	2017	JRNL0019	11/30/17	Resident matter		

Total 112

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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **AHCA / IHCA $4,144**

(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. $ **12,998** 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. $ **140,595**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

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

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 1**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

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