		FOR BHF USE					

LL1

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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 01/01/18 to 12/31/18 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) Carol Sparks
(Title) Director of Reimbursement

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: 01/01/18 Ending: 12/31/18

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	Skilled (SNF)	36	13,140	1
2		Skilled Pediatric (SNF/PED)			2
3	72	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	665	1,732	2,929	5,326	8
9	SNF/PED					9
10	ICF	7,063	4,332	482	11,877	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,728	6,064	3,411	17,203	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 43.64%

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 1,806

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: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number Hilltop Skilled Nsg & Rehab # 0051441 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	123,879	8,477	5,453	137,809	0	137,809	0	137,809			1
2	Food Purchase		88,219		88,219	0	88,219	0	88,219			2
3	Housekeeping	47,567	10,022	1,623	59,212	0	59,212	0	59,212			3
4	Laundry	17,376	3,286	35	20,697	0	20,697	0	20,697			4
5	Heat and Other Utilities			72,768	72,768	0	72,768	0	72,768			5
6	Maintenance	48,952	8,021	29,620	86,593	0	86,593	0	86,593			6
7	Other (specify):*	0	0	0	0	0	0	0	0			7
8	**TOTAL General Services**	237,774	118,025	109,499	465,298	0	465,298	0	465,298			8
	B. Health Care and Programs											
9	Medical Director	0	0	24,014	24,014	0	24,014	0	24,014			9
10	Nursing and Medical Records	954,829	43,628	8,696	1,007,153	0	1,007,153	0	1,007,153			10
10a	Therapy	0	0	327,273	327,273	0	327,273	0	327,273			10a
11	Activities	23,797	1,000	2,179	26,976	0	26,976	0	26,976			11
12	Social Services	29,756	0	1,929	31,685	0	31,685	0	31,685			12
13	CNA Training	0	0	0	0	0	0	0	0			13
14	Program Transportation	0	0	6,656	6,656	0	6,656	0	6,656			14
15	Other (specify):* **HO Direct**	0	0	0	0	0	0	18,614	18,614			15
16	**TOTAL Health Care and Programs**	1,008,382	44,628	370,747	1,423,757	0	1,423,757	18,614	1,442,371			16
	C. General Administration											
17	Administrative	69,581	0	159,672	229,253	0	229,253	56,773	286,026			17
18	Directors Fees			0	0	0	0	0	0			18
19	Professional Services			61,110	61,110	0	61,110	0	61,110			19
20	Dues, Fees, Subscriptions & Promotions			12,246	12,246	0	12,246	(2,119)	10,127			20
21	Clerical & General Office Expenses	53,845	26,463	103,005	183,313	0	183,313	(73,337)	109,976			21
22	Employee Benefits & Payroll Taxes			310,565	310,565	0	310,565	(8,346)	302,219			22
23	Inservice Training & Education			0	0	0	0	0	0			23
24	Travel and Seminar			2,694	2,694	0	2,694	0	2,694			24
25	Other Admin. Staff Transportation		0	800	800	0	800	0	800			25
26	Insurance-Prop.Liab.Malpractice			196,675	196,675	0	196,675	0	196,675			26
27	Other (specify):* **Contract Admin**	37,822	0	9,555	47,377	0	47,377	(46,677)	700			27
28	**TOTAL General Administration**	161,248	26,463	856,322	1,044,033	0	1,044,033	(73,706)	970,327			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,407,404	189,116	1,336,568	2,933,088	0	2,933,088	(55,092)	2,877,996			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: 01/01/18 Ending: 12/31/18

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	D. Ownership	Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
30	Depreciation			130,758	130,758	0	130,758	121,649	252,407			30
31	Amortization of Pre-Op. & Org.			0	0	0	0	0	0			31
32	Interest			0	0	0	0	30,848	30,848			32
33	Real Estate Taxes			34,982	34,982	0	34,982	(3,248)	31,734			33
34	Rent-Facility & Grounds			157,404	157,404	0	157,404	(157,404)	0			34
35	Rent-Equipment & Vehicles			25,836	25,836	0	25,836	0	25,836			35
36	Other (specify):* Business Taxes			95	95	0	95	(95)	0			36
37	TOTAL Ownership			349,075	349,075	0	349,075	(8,250)	340,825			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0			38
39	Ancillary Service Centers	75	9,121	121,419	130,615	0	130,615	0	130,615			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	151,060	151,060	0	151,060	0	151,060			42
43	Other (specify):*	0	0	0	0	0	0	0	0			43
44	TOTAL Special Cost Centers	75	9,121	272,479	281,675	0	281,675	0	281,675			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,407,479	198,237	1,958,122	3,563,838	0	3,563,838	(63,342)	3,500,496			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: 01/01/18 Ending: 12/31/18

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 Reference	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	0			9
10	Interest and Other Investment Income	(3,574)	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	(237)	21		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	(62,087)	21		24
25	Fund Raising, Advertising and Promotional	(46,633)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax	0	36		26
27	CNA Training for Non-Employees	0			27
28	Yellow Page Advertising	0			28
29	Other-Attach Schedule	(24,865)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (137,396)		$ 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)	74,054	VII-B	34
35	Other- Attach Schedule	0		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 74,054		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (63,342)		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	Other-Attach Schedule					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 0		47

Hilltop Skilled Nsg & Rehab

ID# 0051441

Report Period Beginning: 01/01/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Independent Living	$ 0	43	1
2	Non-Allowable Benefits (Marketing & ILU)	(8,346)	22	2
3	Non-Allowable PAC Dues	(2,119)	20	3
4	Bank Charges	(4,813)	21	4
5	Collection Agency Fees	(44)	27	5
6	Business Taxes	(95)	36	6
7	Patient Theft and Loss	(60)	21	7
8	Prior Year Expense	(6,140)	21	8
9	Real Estate Tax Accrual	(3,248)	33	9
10		0		10
11		0		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**	(24,865)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hilltop Skilled Nsg & Rehab # 0051441 **Report Period Beginning:** 01/01/18 **Ending:** 12/31/18

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	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	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):* **H.O. Direct Care**	0	0	0	18,614	0	0	0	0	0	0	0	18,614	15
16	**TOTAL Health Care and Programs**	0	0	0	18,614	0	0	0	0	0	0	0	18,614	16
	C. General Administration													
17	Administrative	0	0	0	56,773	0	0	0	0	0	0	0	56,773	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(2,119)	0	0	0	0	0	0	0	0	0	0	(2,119)	20
21	Clerical & General Office Expenses	(73,337)	0	0	0	0	0	0	0	0	0	0	(73,337)	21
22	Employee Benefits & Payroll Taxes	(8,346)	0	0	0	0	0	0	0	0	0	0	(8,346)	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 &**	(46,677)	0	0	0	0	0	0	0	0	0	0	(46,677)	27
28	**TOTAL General Administration**	(130,479)	0	0	56,773	0	0	0	0	0	0	0	(73,706)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(130,479)	0	0	75,387	0	0	0	0	0	0	0	(55,092)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Hilltop Skilled Nsg & Rehab **#** 0051441 **Report Period Beginning:** 01/01/18 **Ending:** 12/31/18

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	23,235	0	0	0	0	0	0	0	121,649	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,574)	0	0	34,422	0	0	0	0	0	0	0	30,848	32
33	Real Estate Taxes	(3,248)	0	0	0	0	0	0	0	0	0	0	(3,248)	33
34	Rent-Facility & Grounds	0	(157,404)	0	0	0	0	0	0	0	0	0	(157,404)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):* **BUSINESS TAX**	(95)	0	0	0	0	0	0	0	0	0	0	(95)	36
37	**TOTAL Ownership**	(6,917)	(58,990)	0	57,657	0	0	0	0	0	0	0	(8,250)	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)**	(137,396)	(58,990)	0	133,044	0	0	0	0	0	0	0	(63,342)	45

Facility Name & ID Number Hilltop Skilled Nsg & Rehab # 0051441 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 157,404	CC Charleston, LLC	100.00%	$	$ (157,404)	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			$ 157,404			$ 98,414	$ * (58,990)	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: 01/01/18 Ending: 12/31/18

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	$ 208,908	Affirma Rehabilitation	100.00%	$ 201,466	$ (7,442)	15
16	V	10a	Occupational Therapy	77,324	Affirma Rehabilitation	100.00%	82,185	4,861	16
17	V	10a	Speech Therapy	41,041	Affirma Rehabilitation	100.00%	43,622	2,581	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			$ 327,273			$ 327,273	$ * 0	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: 01/01/18 Ending: 12/31/18

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%	$ 18,614	$ 18,614	15
16	V	17	Indirect		Covenant Care California, LLC	100.00%	216,445	216,445	16
17	V	32	Interest		Covenant Care California, LLC	100.00%	34,422	34,422	17
18	V	30	Depreciation		Covenant Care California, LLC	100.00%	23,235	23,235	18
19	V	17	Management Fee	159,672	Covenant Care California, LLC	100.00%		(159,672)	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			$ 159,672			$ 292,716	$ * 133,044	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: 01/01/18 Ending: 12/31/18

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 A	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 & REHABILITAT	INDIANA				6
7			COURTYARD HEALTHCARE CENTER	CALIFORNIA				7
8			COVENANT CARE HILLTOP, LLC D/B/A HIL	CHARLESTON				8
9			COVENANT CARE JACKSONVILLE, LLC D/I	JACKSONVILLE				9
10			COVENANT CARE MEADOW MANOR, LLC I	TAYLORVILLE				10
11			COVENANT CARE MIDWEST, INC. D/B/A CE	LEBANON				11
12			COVENANT CARE SUNRISE, LLC D/B/A SUN	VIRDEN				12
13			COVINGTON MANOR	INDIANA				13
14			DOWNEY CARE	CALIFORNIA				14
15			EAGLE POINT NURSING & REHAB CENTER	IOWA				15
16			EDGEWOOD MANOR NURSING CENTER	OHIO				16
17			EMERALD GARDENS NURSING CENTER	CALIFORNIA				17
18			ENCINITAS NURSING AND REHABILITATIC	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 & REHABILITATIO	CALIFORNIA				22
23			GRANT CUESTA NURSING & REHABILITAT	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 & REHABILITATIC	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: 01/01/18 Ending: 12/31/18

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 & REHABILIT	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 CREEI	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 & REHABILITATI	CALIFORNIA				24
25			WRIGHT NURSING & REHAB CENTER (VIL	OHIO				25
26			MARION REHAB AND ASSISTED LIVING CE	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: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

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: 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						$	$		$	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: 01/01/18 Ending: 12/31/18

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			$	$		$ 208,908	1
2	39	Occupational Therapy	Direct Allocation						77,324	2
3	39	Speech Therapy	Direct Allocation						41,041	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					$	$		$ 327,273	25

Facility Name & ID Number Hilltop Skilled Nsg & Rehab # 0051441 Report Period Beginning: 01/01/18 Ending: 12/31/18

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			$	$		$	1
2	15	Direct	Accumulated Cost						18,614	2
3	17	Indirect	Accumulated Cost						216,445	3
4	32	Interest	Accumulated Cost						34,422	4
5	30	Depreciation	Accumulated Cost						23,235	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					$	$		$ 292,716	25

Facility Name & ID Number Hilltop Skilled Nsg & Rehab # 0051441 Report Period Beginning: 01/01/18 Ending: 12/31/18

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Allocated from Covenant Care Inc.		X								34,422	6
7												7
8												8
9	TOTAL Facility Related						$ 0	$ 0			$ 34,422	9
	B. Non-Facility Related*											
10	Interest Income		X								(3,574)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ (3,574)	14
15	TOTALS (line 9+line14)						$ 0	$ 0			$ 30,848	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: 01/01/18 Ending: 12/31/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 36,743	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.)		$ 33,495	2
3. Under or (over) accrual (line 2 minus line 1).		$ (3,248)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 34,982	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		$ 31,734	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	33,258	8
	2014	31,063	9
	2015	36,361	10
	2016	36,743	11
	2017	33,495	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 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 2017 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 2017.

	(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	$ 33,495.32	$ 33,495.32
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 33,495.32	$ 33,495.32

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

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	0	103,335	67
68	Related Party Allocations (Pages 12H & 12I)			23,235		23,235			68
69	Financial Statement Depreciation			117,267		117,267		688,571	69
70	TOTAL (lines 4 thru 69)		$ 1,618,390	$ 170,026		$ 170,027	$ 0	$ 791,906	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: 01/01/18 Ending: 12/31/18

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	$ 170,026		$ 170,027	$ 0	$ 791,906	1
2	2 Ton A/C Unit	2013	4,162	208	20	208		1,040	2
3	Repair Roof	2013	3,000	150	20	150		750	3
4	5 Ton 3 Phase Condensor Ac Unit	2014	3,150	158	20	158		631	4
5	Booster Heater Water Heater	2016	2,543	254	20	254		508	5
6	Asphalt Paving, Sidewalk Replacement, Roofing, Plumbing	2016	85,887	4,294	20	4,294		8,588	6
7	Garbage Disposal	2017	1,126	148	7	148	(0)	148	7
8	Wanderguard Report	2017	17,400		7	0		0	8
9	Water Heater	2018	3,679		7			307	9
10	Accumulated Depreciation and Depreciation			(9,081)		(9,081)		68,877	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)		$ 1,739,338	$ 166,157		$ 166,157	$ (0)	$ 872,755	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: 01/01/18 Ending: 12/31/18

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	$ 0	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	$ 594,836	$ 85,740	$ 85,740	$ 0		$ 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	$ 0		$ 2,041	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 10,715	$ 510	$ 510	$ 0		$ 2,041	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)	$	2,344,889	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	252,407	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	252,407	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	(0)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	1,272,796	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.

Facility Name & ID Number Hilltop Skilled Nsg & Rehab # 0051441 Report Period Beginning: 01/01/18 Ending: 12/31/18

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:				$ 157,404			3
4	Additions							4
5								5
6								6
7	TOTAL				$ 157,404 **			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 ☒ X NO
16. Rental Amount for movable equipment: $ 25,836 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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Company	Locn	Dept	Account	Journal_Desc	Amount	Month	Year	JournalNumb	ApplyDate
CCMIDWST	076	6110	60000620	Acc 9/18 ISV J	23.76	9	2018	JRNL0019928	09/30/18
CCMIDWST	076	6110	60000620	Acc 9/18 ISV J	-23.76	10	2018	JRNL0019969	10/31/18
CCMIDWST	076	6110	60000620	ISAVE - JOERN	23.76	10	2018	JRNL0019974	10/15/18
CCMIDWST	076	6110	60000620	LINCOLNLAND	40	11	2018	JRNL0020021	11/16/18
CCMIDWST	076	6110	60000620	LINCOLNLAND	40	11	2018	JRNL0020021	11/16/18
CCMIDWST	076	6110	60000620	LINCOLNLAND	40	11	2018	JRNL0020021	11/16/18
CCMIDWST	076	6110	60000620	LINCOLNLAND	40	11	2018	JRNL0020021	11/16/18
CCMIDWST	076	6110	60000620	LINCOLNLAND	40	11	2018	JRNL0020021	11/16/18
CCMIDWST	076	6110	60000620	LINCOLNLAND	40	11	2018	JRNL0020021	11/16/18
CCMIDWST	076	6110	60000620	LINCOLNLAND	40	12	2018	JRNL0020092	12/27/18
CCMIDWST	076	6110	60000620	LINCOLNLAND	40	12	2018	JRNL0020102	12/31/18
CCMIDWST	076	6110	60000620	LINCOLNLAND	40	12	2018	JRNL0020102	12/31/18
CCMIDWST	076	6110	60000620	LINCOLNLAND	40	12	2018	JRNL0020102	12/31/18
CCMIDWST	076	6110	60000620	LINCOLNLAND	40	12	2018	JRNL0020102	12/31/18
CCMIDWST	076	6110	60000620	LINCOLNLAND	40	12	2018	JRNL0020102	12/31/18
CCMIDWST	076	6200	60000620	FIVE STAR REI	18	4	2018	JRNL0019473	04/30/18
CCMIDWST	076	6200	60000620	FIVE STAR REI	144	10	2018	JRNL0019977	10/30/18
CCMIDWST	076	6200	60000620	FIVE STAR REI	144	10	2018	JRNL0019977	10/30/18
CCMIDWST	076	6500	60000620	ECOLAB - 076	75.88	1	2018	JRNL0019239	01/31/18
CCMIDWST	076	6500	60000620	ECOLAB - 076	75.88	2	2018	JRNL0019327	02/28/18
CCMIDWST	076	6500	60000620	ECOLAB - 076	75.88	3	2018	JRNL0019404	03/31/18
CCMIDWST	076	6500	60000620	ECOLAB - 076	75.88	4	2018	JRNL0019479	04/30/18
CCMIDWST	076	6500	60000620	ECOLAB - 076	75.88	5	2018	JRNL0019594	05/31/18
CCMIDWST	076	6500	60000620	ECOLAB - 076	75.88	6	2018	JRNL0019680	06/30/18
CCMIDWST	076	6500	60000620	ECOLAB - 076	75.88	7	2018	JRNL0019761	07/31/18
CCMIDWST	076	6500	60000620	ECOLAB - 076	75.88	8	2018	JRNL0019841	08/31/18
CCMIDWST	076	6500	60000620	ECOLAB - 076	75.88	9	2018	JRNL0019910	09/30/18
CCMIDWST	076	6500	60000620	ECOLAB - 076	75.88	10	2018	JRNL0019982	10/31/18
CCMIDWST	076	6500	60000620	ECOLAB - 076	75.88	11	2018	JRNL0020049	11/30/18
CCMIDWST	076	6500	60000620	ECOLAB - 076	75.88	12	2018	JRNL0020102	12/31/18
CCMIDWST	076	6700	60000620	GANO WELDII	36	6	2018	JRNL0019680	06/30/18
CCMIDWST	076	6901	60000620	FIVE STAR REI	171.75	11	2018	JRNL0020027	11/20/18
CCMIDWST	076	6901	60000620	GANO WELDII	36	1	2018	JRNL0019239	01/31/18
CCMIDWST	076	6901	60000620	HEWLETT-PAC	99.62	5	2018	JRNL0019555	05/30/18
CCMIDWST	076	6901	60000620	HEWLETT-PAC	99.62	5	2018	JRNL0019555	05/30/18
CCMIDWST	076	6901	60000620	HEWLETT-PAC	99.62	5	2018	JRNL0019555	05/30/18
CCMIDWST	076	6901	60000620	HEWLETT-PAC	99.62	5	2018	JRNL0019555	05/30/18
CCMIDWST	076	6901	60000620	HEWLETT-PAC	99.62	6	2018	JRNL0019559	06/01/18
CCMIDWST	076	6901	60000620	HEWLETT-PAC	99.62	7	2018	JRNL0019625	07/01/18
CCMIDWST	076	8131	60000620	Acc 1/18 ISV J	170.5	1	2018	JRNL0019265	01/31/18
CCMIDWST	076	8131	60000620	Acc 1/18 ISV J	-170.5	2	2018	JRNL0019336	02/28/18
CCMIDWST	076	8131	60000620	Acc 1/18 ISV J	93.5	1	2018	JRNL0019265	01/31/18
CCMIDWST	076	8131	60000620	Acc 1/18 ISV J	-93.5	2	2018	JRNL0019336	02/28/18
CCMIDWST	076	8131	60000620	Acc 12/17 ISV	-170.5	1	2018	JRNL0019252	01/31/18
CCMIDWST	076	8131	60000620	Acc 2/18 ISV J	110	2	2018	JRNL0019333	02/28/18
CCMIDWST	076	8131	60000620	Acc 2/18 ISV J	-110	3	2018	JRNL0019393	03/31/18
CCMIDWST	076	8131	60000620	Acc 2/18 ISV J	110	2	2018	JRNL0019333	02/28/18
CCMIDWST	076	8131	60000620	Acc 2/18 ISV J	-110	3	2018	JRNL0019393	03/31/18
CCMIDWST	076	8131	60000620	Acc 7/18 Joer	924	7	2018	JRNL0019755	07/31/18
CCMIDWST	076	8131	60000620	Acc 7/18 Joer	-924	8	2018	JRNL0019827	08/31/18
CCMIDWST	076	8131	60000620	Acc 7/18 Joer	504	7	2018	JRNL0019755	07/31/18
CCMIDWST	076	8131	60000620	Acc 7/18 Joer	-504	8	2018	JRNL0019827	08/31/18
CCMIDWST	076	8131	60000620	Acc 8/18 ISV J	336	8	2018	JRNL0019846	08/31/18
CCMIDWST	076	8131	60000620	Acc 8/18 ISV J	-336	9	2018	JRNL0019900	09/30/18
CCMIDWST	076	8131	60000620	Acc 8/18 ISV J	336	8	2018	JRNL0019846	08/31/18
CCMIDWST	076	8131	60000620	Acc 8/18 ISV J	-336	9	2018	JRNL0019900	09/30/18
CCMIDWST	076	8131	60000620	Acc 8/18 ISV J	262.5	8	2018	JRNL0019846	08/31/18
CCMIDWST	076	8131	60000620	Acc 8/18 ISV J	-262.5	9	2018	JRNL0019900	09/30/18
CCMIDWST	076	8131	60000620	Acr exp batch	155	6	2018	JRNL0019700	06/30/18
CCMIDWST	076	8131	60000620	Acr exp batch	-155	7	2018	JRNL0019717	07/31/18
CCMIDWST	076	8131	60000620	CARLE MEDIC	26	6	2018	JRNL0019624	06/19/18
CCMIDWST	076	8131	60000620	CARLE MEDIC	286	6	2018	JRNL0019624	06/19/18
CCMIDWST	076	8131	60000620	CARLE MEDIC	182	6	2018	JRNL0019624	06/19/18
CCMIDWST	076	8131	60000620	CARLE MEDIC	546	6	2018	JRNL0019649	06/30/18
CCMIDWST	076	8131	60000620	CARLE MEDIC	364	7	2018	JRNL0019781	07/31/18
CCMIDWST	076	8131	60000620	CARLE MEDIC	286	7	2018	JRNL0019781	07/31/18
CCMIDWST	076	8131	60000620	CARLE MEDIC	364	7	2018	JRNL0019781	07/31/18
CCMIDWST	076	8131	60000620	CR- Joerns 1Q	-29.04	5	2018	JRNL0019604	05/31/18
CCMIDWST	076	8131	60000620	CR- Joerns 4Q	-260.05	2	2018	JRNL0019377	02/28/18
CCMIDWST	076	8131	60000620	ISAVE - JOERN	170.5	1	2018	JRNL0019222	01/08/18
CCMIDWST	076	8131	60000620	ISAVE - JOERN	170.5	2	2018	JRNL0019322	02/12/18
CCMIDWST	076	8131	60000620	ISAVE - JOERN	93.5	2	2018	JRNL0019322	02/12/18
CCMIDWST	076	8131	60000620	ISAVE - JOERN	110	3	2018	JRNL0019391	03/05/18
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CCMIDWST	076	8131	60000620	ISAVE - JOERN	504	8	2018	JRNL0019800	08/13/18
CCMIDWST	076	8131	60000620	ISAVE - JOERN	924	8	2018	JRNL0019800	08/13/18
CCMIDWST	076	8131	60000620	ISAVE - JOERN	336	9	2018	JRNL0019871	09/10/18
CCMIDWST	076	8131	60000620	ISAVE - JOERN	262.5	9	2018	JRNL0019871	09/10/18
CCMIDWST	076	8131	60000620	ISAVE - JOERN	336	9	2018	JRNL0019871	09/10/18
CCMIDWST	076	8131	60000620	LINCOLNLAND	40	3	2018	JRNL0019404	03/31/18
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CCMIDWST	076	8131	60000620	LINCOLNLAND	120	3	2018	JRNL0019404	03/31/18
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CCMIDWST	076	8131	60000620	LINCOLNLAND	120	6	2018	JRNL0019622	06/18/18
CCMIDWST	076	8131	60000620	LINCOLNLAND	120	6	2018	JRNL0019622	06/18/18
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CCMIDWST	076	8131	60000620	LINCOLNLAND	140	6	2018	JRNL0019622	06/18/18
CCMIDWST	076	8131	60000620	LINCOLNLAND	80	6	2018	JRNL0019622	06/18/18
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CCMIDWST	076	8131	60000620	LINCOLNLAND	40	6	2018	JRNL0019622	06/18/18
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CCMIDWST	076	8131	60000620	LINCOLNLAND	40	10	2018	JRNL0019954	10/16/18
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CCMIDWST	076	8131	60000620	LINCOLNLAND	40	12	2018	JRNL0020102	12/31/18
CCMIDWST	076	8131	60000620	LINCOLNLAND	40	12	2018	JRNL0020102	12/31/18
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CCMIDWST	076	8131	60000620	LINCOLNLAND	40	12	2018	JRNL0020102	12/31/18
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CCMIDWST	076	8131	60000620	Rcl Carle Med	494	10	2018	JRNL0020014	10/31/18
CCMIDWST	076	8131	60000620	ZOLL SERVICE	2325	5	2018	JRNL0019567	05/31/18
CCMIDWST	076	8200	60000620	ACCELERATED	982	1	2018	JRNL0019220	01/25/18
CCMIDWST	076	8200	60000620	ACCELERATED	982	2	2018	JRNL0019301	02/25/18
CCMIDWST	076	8200	60000620	ACCELERATED	982	3	2018	JRNL0019388	03/25/18
CCMIDWST	076	8200	60000620	ACCELERATED	982	4	2018	JRNL0019464	04/25/18
CCMIDWST	076	8200	60000620	ACCELERATED	982	5	2018	JRNL0019552	05/25/18
CCMIDWST	076	8200	60000620	ACCELERATED	982	6	2018	JRNL0019639	06/25/18
CCMIDWST	076	8200	60000620	ACCELERATED	982	7	2018	JRNL0019731	07/25/18
CCMIDWST	076	8200	60000620	ACCELERATED	982	8	2018	JRNL0019814	08/25/18
CCMIDWST	076	8200	60000620	ACCELERATED	982	9	2018	JRNL0019898	09/25/18
CCMIDWST	076	8200	60000620	ACCELERATED	982	10	2018	JRNL0019965	10/25/18
CCMIDWST	076	8200	60000620	ACCELERATED	982	11	2018	JRNL0020035	11/25/18
CCMIDWST	076	8200	60000620	ACCELERATED	982	12	2018	JRNL0020092	12/25/18
					25,836				

Facility Name & ID Number Hilltop Skilled Nsg & Rehab # 0051441 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	0.00 hrs	$ 0	1,487	$ 77,324	$ 0	1,487	$ 77,324	1
2	Licensed Speech and Language Development Therapist	V10A	0.00 hrs	0	945	41,041	0	945	41,041	2
3	Licensed Recreational Therapist	V10A	0.00 hrs	0	0	0	0			3
4	Licensed Physical Therapist	V10A	0.00 hrs	0	4,913	208,908	0	4,913	208,908	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	V39	5.91 hrs	75	0	0	559	6	634	8
9	Pharmacy	V39	0.00 # of prescrpts	0	0	0	109,879		109,879	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): LAB/RADIOLOGY	V39	0.00	0	0	0	7,905		7,905	12
13	Other (specify): BILLABLE SUPPLIES	V39	0.00	0	0	0	12,197		12,197	13
14	TOTAL			$ 75	7,345	$ 327,273	$ 130,540	7,351	$ 457,888	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: 01/01/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/18 (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 197,338)	512,779	512,779	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	166	166	7
8	Accounts Receivable (owners or related parties)	0		8
9	Other(specify): Inventories	8,954	8,954	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 568,658	$ 568,658	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	853,607	853,607	15
16	Equipment, at Historical Cost	261,102	605,552	16
17	Accumulated Depreciation (book methods)	(928,346)	(1,272,796)	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 Settlement	3,906	3,906	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 190,269	$ 1,075,999	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 758,927	$ 1,644,657	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	66,338	66,338	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 Liability	2,488,974	3,259,514	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,555,312	$ 3,325,852	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 & Deferred Rent	33,322	33,322	43
44		0		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 33,322	$ 33,322	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,588,634	$ 3,359,174	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,829,707)	$ (1,714,517)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 758,927	$ 1,644,657	48

*(See instructions.)

Mid West SNF/RES
077-CC Charleston, LLC (#076)
For the Month Ending December 31, 2018

Acct Number	Dept	Acount	Description	***YTD Amount***
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	**(103,335.11)**
077-0000-12910000	0000	12910000	ACC DEPR - MAJOR MOVABLE EQUIP	**(241,114.91)**
077-0000-20800099	0000	20800099	INTERCOMPANY	**(770,539.89)**
077-0000-24400100	0000	24400100	EQUITY - RETAINED EARNINGS	**(110,210.29)**
077-0000-29990000	0000	29990000	CURRENT YEAR PROFIT/LOSS	**54,009.91**
077-7100-70009220	7100	70009220	PROPERTY DEPR-BLDGS & IMPROVEMENTS	**29,524.32**
077-7100-70009240	7100	70009240	PROPERTY DEPR-MAJOR MOVABLE EQUIP	**68,889.97**
077-8000-40003430	8000	40003430	MISC. REV. RENT INCOME	**(157,404.00)**
			Total	-

Facility Name & ID Number Hilltop Skilled Nsg & Rehab # 0051441 Report Period Beginning: 01/01/18 Ending: 12/31/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,471,868)	1
2	Restatements (describe):		2
3	**Prior Period Adj.**	6,957	3
4	**0**	0	4
5	**0**	0	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,464,911)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(364,796)	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)**	$ (364,796)	17
	B. Transfers (Itemize):		
18	**ILU net asset activity for the year**	0	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)**	$ (1,829,707)	24 *

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

Facility Name & ID Number Hilltop Skilled Nsg & Rehab # 0051441 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 2,657,418	1
2	Discounts and Allowances for all Levels	(573,542)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,083,876	3
	B. Ancillary Revenue		
4	Day Care	0	4
5	Other Care for Outpatients	0	5
6	Therapy	989,402	6
7	Oxygen	0	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 989,402	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	103,944	17
18	Sale of Supplies to Non-Patients	0	18
19	Laboratory	2,769	19
20	Radiology and X-Ray	2,938	20
21	Other Medical Services	12,539	21
22	Laundry	0	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 122,190	23
	D. Non-Operating Revenue		
24	Contributions	0	24
25	Interest and Other Investment Income***	3,574	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,574	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)	0	27
28	AL/IL	0	28
28a	Misc Revenue	0	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 0	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,199,042	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	465,298	31
32	Health Care	1,423,757	32
33	General Administration	1,044,033	33
	B. Capital Expense		
34	Ownership	349,075	34
	C. Ancillary Expense		
35	Special Cost Centers	130,615	35
36	Provider Participation Fee	151,060	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)***	$ 3,563,838	40
41	**Income before Income Taxes (line 30 minus line 40)****	(364,796)	41
42	**Income Taxes**	0	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (364,796)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 975,545	44
45	Private Pay - Net Inpatient Revenue	938,277	45
46	Medicare - Net Inpatient Revenue	858,825	46
47	Other-(specify) ALL OTHER SNF/SCF IP REVENUE	303,980	47
48	Other-(specify) C/A ANCILLARY ACCOUNTS	(992,751)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3	$ 2,083,876	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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.**

Facility Name & ID Number Hilltop Skilled Nsg & Rehab # 0051441 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	1,862	1,892	$ 76,923	$ 40.66	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	2,430	3,191	83,697	26.23	3
4	Licensed Practical Nurses	16,058	16,058	416,256	25.92	4
5	CNAs & Orderlies	25,913	25,913	357,438	13.79	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	6	6	75	12.50	8
9	Activity Director	1,585	1,585	20,230	12.76	9
10	Activity Assistants	110	168	3,567	21.23	10
11	Social Service Workers	1,824	1,868	29,756	15.93	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	1,923	1,923	32,694	17.00	13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	8,648	8,795	91,185	10.37	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	1,672	1,696	48,952	28.86	17
18	Housekeepers	4,242	4,320	47,567	11.01	18
19	Laundry	1,934	1,955	17,376	8.89	19
20	Administrator	1,735	1,751	69,581	39.74	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	0	0	0		22
23	Office Manager	0	0	0		23
24	Clerical	1,687	1,740	53,845	30.95	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	0	0	0		31
32	Other Health Care(specify)	632	633	20,515	32.41	32
33	Other(specify) Marketing	1,745	1,800	37,822	21.01	33
34	TOTAL (lines 1 - 33)	74,006	75,294	$ 1,407,479 *	$ 18.69	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	0	$ 5,453		35
36	Medical Director	0	24,000		36
37	Medical Records Consultant	0	2,040		37
38	Nurse Consultant	0	0		38
39	Pharmacist Consultant	0			39
40	Physical Therapy Consultant	0	0		40
41	Occupational Therapy Consultant	0	0		41
42	Respiratory Therapy Consultant	0	0		42
43	Speech Therapy Consultant	0	0		43
44	Activity Consultant	0	1,929		44
45	Social Service Consultant	0	1,929		45
46	Other(specify)	0	0		46
47		0	0		47
48		0	0		48
49	TOTAL (lines 35 - 48)		$ 35,350		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	0	$ 0		50
51	Licensed Practical Nurses	0	0		51
52	Certified Nurse Assistants/Aides	0	0		52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Hilltop Skilled Nsg & Rehab # 0051441 Report Period Beginning: 01/01/18 Ending: 12/31/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Emily Masulis	Admin	0	$ 59,004
Jill Buchar	Admin Asst	0	10,577
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 69,581

B. Administrative - Other

Description	Amount
Management Fees- Covenant Care California, LLC	$ 159,672
TOTAL (agree to Schedule V, line 17, col. 3)	$ 159,672
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
	Legal Fees	$ 1,807
Ability Network Inc.	Data Processing	947
Iron Mountain	Data Processing	3,005
National Datacare Corp	Data Processing	1,578
Omnicare Pharmacy	Data Processing	132
Pinnacle Quality Insight	Resident Satisfaction	1,632
Smartlinx Solutions	Work Force Management	5,887
Pointclick Care Technologies	Data Processing	29,473
Verify	Data Processing	2,574
Software Allocation	Software	14,076
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 61,110

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 63,788
Unemployment Compensation Insurance	
FICA Taxes	128,576
Employee Health Insurance	69,114
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Dental Insurance	294
Vision Insurance	25
Other Employee Benefits	38,594
Employee Physicals/X-Rays	0
Life & Disability	1,828
TOTAL (agree to Schedule V, line 22, col.8)	$ 302,219

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	885
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Dues & Subscriptions	6,517
Licenses & Permits	735
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,127

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
	2,175
In-State Travel	
Seminar Expense	519
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,694

**See instructions.

PAGE 21 SUPPLEMENTAL - LEGAL FEE DETAIL

Company	Locn	Dept	Account	Journal_Description	Amount	Month	Year	JournalNumber	ApplyDate	Purpose	(Non)Allowable
CCMIDWST	076	6901	60000470	Acr Sandberg Phoenix 2/18	308.25	2	2018	JRNL00193483	02/28/18	Guardianship	Allowable
CCMIDWST	076	6901	60000470	Acr Sandberg Phoenix 2/18	-308.25	3	2018	JRNL00193579	03/31/18	Guardianship	Allowable
CCMIDWST	076	6901	60000470	Acr Sandberg Phoenix 2/18	308.25	3	2018	JRNL00194255	03/31/18	Guardianship	Allowable
CCMIDWST	076	6901	60000470	Acr Sandberg Phoenix 2/18	-308.25	4	2018	JRNL00194378	04/30/18	Guardianship	Allowable
CCMIDWST	076	6901	60000470	Acr Sandberg Phoenix 2/18	308.25	4	2018	JRNL00195146	04/30/18	Guardianship	Allowable
CCMIDWST	076	6901	60000470	Acr Sandberg Phoenix 2/18	-308.25	5	2018	JRNL00195156	05/31/18	Guardianship	Allowable
CCMIDWST	076	6901	60000470	Rcl 11/18 Sandberg to fac 070	-115	12	2018	JRNL00201414	12/31/18	Collection	NonAllowable
CCMIDWST	076	6901	60000470	Rcl Sandberg Phoenix legal fees	1337.45	7	2018	JRNL00197544	07/31/18	Resident Matter	Allowable
CCMIDWST	076	6901	60000470	SANDBERG,PHOENIX & VON GONTARD - 099	308.25	5	2018	JRNL00195480	05/24/18	Regulatory	Allowable
CCMIDWST	076	6901	60000470	SANDBERG,PHOENIX & VON GONTARD - 099	161	9	2018	JRNL00199123	09/30/18	Guardianship	Allowable
CCMIDWST	076	6901	60000470	SANDBERG,PHOENIX & VON GONTARD - 099	115	11	2018	JRNL00200484	11/30/18	Collection	NonAllowable
					1,806.70						

Facility Name & ID Number Hilltop Skilled Nsg & Rehab # 0051441 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 $5,009**

(3) Did the nursing home make political contributions or payments to a politica 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 expens and the location of this expense on Sch. V. $ **12,406** Line **10**

(7) Have all costs reported on this form been determined using accounting procedure 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 fo 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 Departmen during this cost report period. $ **151,060**
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 t the Department, in addition to the daily rate, been properly classifiec 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 fo 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 benefit 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 fo 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 othe times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjustec 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 ou 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