

Facility Name & ID Number Cedar Ridge Hlth & Rehab Ctr

0042838 Report Period Beginning: 01/01/16 Ending: 12/31/16

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	116	Skilled (SNF)	116	42,456	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	116	TOTALS	116	42,456	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	23,927	4,700	8,611	37,238	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,927	4,700	8,611	37,238	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.71%

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

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

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

Outpatient Therapy

F. Does the facility maintain a daily midnight census?

Yes

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

YES NO

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

YES NO

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

Date started 1/1/1994

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

YES Date 4/1/1997 NO

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

YES NO If YES, enter number of beds certified 116 and days of care provided 4,387

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/16 Fiscal Year: 12/31/16

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

Facility Name & ID Number Cedar Ridge Hlth & Rehab Ctr # 0042838 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	218,514	21,893	18,999	259,406		259,406		259,406		1
2	Food Purchase		171,010		171,010		171,010	(216)	170,794		2
3	Housekeeping	119,033	22,319	4,910	146,262		146,262		146,262		3
4	Laundry	60,205	10,119		70,324		70,324		70,324		4
5	Heat and Other Utilities			115,410	115,410		115,410	(5,246)	110,164		5
6	Maintenance	73,635	29,890	113,946	217,471		217,471	6,763	224,234		6
7	Other (specify):*										7
8	TOTAL General Services	471,387	255,231	253,265	979,883		979,883	1,301	981,184		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	2,382,509	119,374	9,845	2,511,728		2,511,728		2,511,728		10
10a	Therapy	42,786	34,752		77,538		77,538		77,538		10a
11	Activities	66,630	15,245	1,735	83,610		83,610		83,610		11
12	Social Services	155,842	2,117	1,735	159,694		159,694		159,694		12
13	CNA Training										13
14	Program Transportation			19,142	19,142		19,142		19,142		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,647,767	171,488	44,457	2,863,712		2,863,712		2,863,712		16
	C. General Administration										
17	Administrative	85,450		449,128	534,578		534,578	(214,121)	320,457		17
18	Directors Fees										18
19	Professional Services			69,977	69,977		69,977	86,831	156,808		19
20	Dues, Fees, Subscriptions & Promotions			66,375	66,375		66,375	(45,339)	21,036		20
21	Clerical & General Office Expenses	224,011	30,550	252,853	507,414		507,414	(198,125)	309,289		21
22	Employee Benefits & Payroll Taxes			637,790	637,790		637,790		637,790		22
23	Inservice Training & Education										23
24	Travel and Seminar			706	706		706	33,954	34,660		24
25	Other Admin. Staff Transportation			35,241	35,241		35,241	(1,461)	33,780		25
26	Insurance-Prop.Liab.Malpractice			239,850	239,850		239,850	7,184	247,034		26
27	Other (specify):*							63,535	63,535		27
28	TOTAL General Administration	309,461	30,550	1,751,920	2,091,931		2,091,931	(267,541)	1,824,390		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,428,615	457,269	2,049,642	5,935,526		5,935,526	(266,240)	5,669,286		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			63,430	63,430		63,430	(418)	63,012		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			619	619		619	51,819	52,438		32
33	Real Estate Taxes			86,620	86,620		86,620	1,542	88,162		33
34	Rent-Facility & Grounds			524,663	524,663		524,663		524,663		34
35	Rent-Equipment & Vehicles			19,681	19,681		19,681		19,681		35
36	Other (specify):*							43,785	43,785		36
37	TOTAL Ownership			695,013	695,013		695,013	96,729	791,742		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		377,111	887,999	1,265,110		1,265,110		1,265,110		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			263,090	263,090		263,090		263,090		42
43	Other (specify):*			23,723	23,723		23,723	(23,723)	0		43
44	TOTAL Special Cost Centers		377,111	1,174,812	1,551,923		1,551,923	(23,723)	1,528,200		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,428,615	834,380	3,919,467	8,182,462		8,182,462	(193,234)	7,989,228		45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(5,246)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(418)	30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(216)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(8,190)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(160,807)	21		24
25	Fund Raising, Advertising and Promotional	(43,516)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(56,809)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (275,202)		\$	30

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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	81,968		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 81,968		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (193,234)		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	2	3	4
		Yes	No	Amount	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

BHF USE ONLY							
48		49		50		51	
							52

Cedar Ridge Hlth & Rehab Ctr

ID# 0042838

Report Period Beginning: 01/01/16

Ending: 12/31/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Bank Charges	\$ (9,781)	21	1
2	Business Taxes	(411)	21	2
3	Theft and Loss	(122)	21	3
4	Prior Year Expense	(6,250)	21	4
5	Other Revenue	(14,673)	21	5
6	Additional R&M	4,320	06	6
7	PAC Dues	(2,678)	20	7
8	Real Estate Taxes	1,542	33	8
9	Non - Allowable Legal	(2,943)	19	9
10	Non - Allowable Expense	(23,723)	43	10
11	Non-Allowable Travel	(1,461)	25	11
12	Chamber of Commerce Dues	(630)	20	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(56,809)		49

Cedar Ridge Hlth & Rehab Ctr

ID# 0042838

Report Period Beginning: 01/01/16

Ending: 12/31/16

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Cedar Ridge Hlth & Rehab Ctr

0042838

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(216)											(216)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(5,246)											(5,246)	5
6	Maintenance	4,320			2,443								6,763	6
7	Other (specify):*													7
8	TOTAL General Services	(1,142)			2,443								1,301	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs													16
	C. General Administration													
17	Administrative				(214,121)								(214,121)	17
18	Directors Fees													18
19	Professional Services	(2,943)			89,774								86,831	19
20	Fees, Subscriptions & Promotions	(46,824)			1,485								(45,339)	20
21	Clerical & General Office Expenses	(200,234)			2,108								(198,125)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar				33,954								33,954	24
25	Other Admin. Staff Transportation	(1,461)											(1,461)	25
26	Insurance-Prop.Liab.Malpractice				7,184								7,184	26
27	Other (specify):*				63,535								63,535	27
28	TOTAL General Administration	(251,461)			(16,080)								(267,541)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(252,603)			(13,637)								(266,240)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Cedar Ridge Hlth & Rehab Ctr # 0042838 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	(418)											(418)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest				51,819								51,819	32
33	Real Estate Taxes	1,542											1,542	33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*				43,785								43,785	36
37	TOTAL Ownership	1,124			95,605								96,729	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(23,723)											(23,723)	43
44	TOTAL Special Cost Centers	(23,723)											(23,723)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(275,202)			81,968								(193,234)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							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		\$			\$	\$ *	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39 Physical Therapy	\$ 400,020	Affirma Rehabilitation	100.00%	\$ 400,020	\$	15
16	V	39 Occupational Therapy	272,146	Affirma Rehabilitation	100.00%	272,146		16
17	V	39 Speech Therapy	177,578	Affirma Rehabilitation	100.00%	177,578		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		\$ 849,744			\$ 849,744	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	6 Maintenance	\$	Covenant Care California, LLC	100.00%	\$ 2,443	\$	2,443	15
16	V	17 Administrative		Covenant Care California, LLC	100.00%	235,007		235,007	16
17	V	19 Professional Services		Covenant Care California, LLC	100.00%	89,774		89,774	17
18	V	20 Dues & Subscriptions		Covenant Care California, LLC	100.00%	1,485		1,485	18
19	V	21 Clerical / Office		Covenant Care California, LLC	100.00%	2,108		2,108	19
20	V	24 Seminar		Covenant Care California, LLC	100.00%	33,954		33,954	20
21	V	26 Insurance		Covenant Care California, LLC	100.00%	7,184		7,184	21
22	V	27 Employee Benefits		Covenant Care California, LLC	100.00%	63,535		63,535	22
23	V	32 Interest		Covenant Care California, LLC	100.00%	51,819		51,819	23
24	V	36 Building, Equipment, Fixtures		Covenant Care California, LLC	100.00%	43,785		43,785	24
25	V								25
26	V	17 Management Fees	449,128					(449,128)	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		\$ 449,128			\$ 531,096	\$ *	81,968	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

Facility Name & ID Number

Cedar Ridge Hlth & Rehab Ctr

0042838

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

Facility Name & ID Number

Cedar Ridge Hlth & Rehab Ctr

0042838

Report Period Beginning:

01/01/16

Ending:

12/31/16

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 & REHABILITATION CENTER	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 CENTER	CALIFORNIA				10
11			THE RESIDENCE AT MCCORMICK'S CREEK	INDIANA				11
12			TURLOCK NURSING AND REHABILITATION CENTER	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 & REHABILITATION CENTER	CALIFORNIA				19
20			VINTAGE FAIRE RESIDENTIAL	CALIFORNIA				20
21			WAGNER HEIGHTS NURSING & REHABILITATION CENTER	CALIFORNIA				21
22			WAGNER HEIGHTS RESIDENTIAL	CALIFORNIA				22
23			WALDRON HEALTH AND REHAB CENTER	INDIANA				23
24			WILLOW TREE NURSING & REHABILITATION CENTER	CALIFORNIA				24
25			WRIGHT NURSING & REHAB CENTER (VILLA FAIRBORN)	OHIO				25
26			MARION REHAB AND ASSISTED LIVING CENTER	INDIANA				26
27			PYRAMID POINT POST ACUTE REHABILITATION CENTER	INDIANA				27
28								28
29								29
30								30

Facility Name & ID Number Cedar Ridge Hlth & Rehab Ctr # 0042838 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$	1	
2										2	
3										3	
4										4	
5										5	
6										6	
7										7	
8										8	
9										9	
10										10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$	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 Cedar Ridge Hlth & Rehab Ctr

0042838

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Cedar Ridge Hlth & Rehab Ctr

0042838

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

()

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Physical Therapy	Direct Allocation		\$	\$		\$ 400,020	1
2	39	Occupational Therapy	Direct Allocation					272,146	2
3	39	Speech Therapy	Direct Allocation					177,578	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				\$	\$		\$ 849,744	25

Facility Name & ID Number Cedar Ridge Hlth & Rehab Ctr

0042838

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Accumulated Cost		\$	\$		\$ 2,443	1
2	17	Administrative	Accumulated Cost					235,007	2
3	19	Professional Services	Accumulated Cost					89,774	3
4	20	Dues & Subscriptions	Accumulated Cost					1,485	4
5	21	Clerical / Office	Accumulated Cost					2,108	5
6	24	Seminar	Accumulated Cost					33,954	6
7	26	Insurance	Accumulated Cost					7,184	7
8	27	Employee Benefits	Accumulated Cost					63,535	8
9	32	Interest	Accumulated Cost					51,819	9
10	36	Building, Equipment, Fixtures	Accumulated Cost					43,785	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				\$	\$		\$ 531,096	25

Facility Name & ID Number Cedar Ridge Hlth & Rehab Ctr

0042838

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Cedar Ridge Hlth & Rehab Ctr

0042838

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Cedar Ridge Hlth & Rehab Ctr

0042838

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Cedar Ridge Hlth & Rehab Ctr

0042838

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Cedar Ridge Hlth & Rehab Ctr

0042838

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Cedar Ridge Hlth & Rehab Ctr

0042838

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Cedar Ridge Hlth & Rehab Ctr

0042838

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number

Cedar Ridge Hlth & Rehab Ctr

0042838

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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	Alloc from Covenant Care Calif	X										51,819	6					
7													7					
8					-								8					
9	TOTAL Facility Related						\$	\$			\$	51,819	9					
B. Non-Facility Related*																		
10	Misc Interest		X									619	10					
11													11					
12													12					
13					-								13					
14	TOTAL Non-Facility Related						\$	\$			\$	619	14					
15	TOTALS (line 9+line14)						\$	\$			\$	52,439	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

Cedar Ridge Hlth & Rehab Ctr

0042838

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1																				
2																				
3																				
4																				
5																				
6																				
7	TOTAL Long-Term																			
Working Capital																				
8																				
9																				
10																				
11																				
12																				
13																				
14	TOTAL Working Capital																			
B. Non-Facility Related*																				
15																				
16																				
17																				
18																				
19																				
20	TOTAL Non-Facility Related																			

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Cedar Ridge Hlth & Rehab Ctr COUNTY St Clair

FACILITY IDPH LICENSE NUMBER 0042838

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>04-24.0-407-005</u>	<u>Long Term Care Property</u>	\$ <u>88,161.58</u>	\$ <u>88,161.58</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>88,161.58</u></u>	\$ <u><u>88,161.58</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

IMPORTANT NOTICE

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

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

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

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Cedar Ridge Hlth & Rehab Ctr COUNTY St Clair

FACILITY IDPH LICENSE NUMBER 0042838

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

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 NO

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

C. Tax Bills

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

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

Facility Name & ID Number Cedar Ridge Hlth & Rehab Ctr

0042838

Report Period Beginning:

01/01/16

Ending:

12/31/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,852 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column with values 1, 2, 3. Row 3 is shaded and labeled TOTALS.

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Various		1993	1,680		20			1,680	9
10	Various		1997	11,984		20			11,984	10
11	Various		1998	9,288		20			9,288	11
12	Various		1999	18,742		20			18,742	12
13	Various		2000	65,946		20	2,524	2,524	58,378	13
14	Various		2001	33,367		20	268	268	32,296	14
15	Various		2002	7,958		20			7,958	15
16	Various		2003	55,604		20	2,039	2,039	23,609	16
17	Various		2004	19,577		20	979	979	14,175	17
18	Various		2005	9,568		20	478	478	5,928	18
19	Various		2006	78,307		20	3,797	3,797	44,134	19
20	Various		2007	23,317		20	823	823	8,228	20
21	Various		2008	156,305		20	7,815	7,815	70,337	21
22	Various		2009	53,739		20	2,687	2,687	21,497	22
23	Various		2010	65,386		20	3,269	3,269	22,885	23
24	Various		2011	21,293		20	1,065	1,065	6,388	24
25	Various		2012	38,807		20	1,940	1,940	9,801	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 Cedar Ridge Hlth & Rehab Ctr

0042838

Report Period Beginning:

01/01/16

Ending:

12/31/16

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69					63,431		(63,431)	69
70		\$ 670,867	\$ 63,431		\$ 27,684	\$ (35,747)	\$ 367,308	70

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

Facility Name & ID Number Cedar Ridge Hlth & Rehab Ctr

0042838

Report Period Beginning:

01/01/16

Ending:

12/31/16

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 670,867	\$ 63,431		\$ 27,684	\$ (35,747)	\$ 367,308	1
2	Remove & Replace Tile Flooring In The Front Hall, Conference R	2013	14,574		20	729	729	2,915	2
3	Replace Furnace, Coil & Air Conditioner	2013	6,896		20	345	345	1,379	3
4	Purchase & Install New Generator	2013	41,082		20	2,054	2,054	8,216	4
5	Dry Sprinkler	2013	4,170		20	209	209	834	5
6	Gas Furnace	2013	4,196		20	210	210	839	6
7	Rebuilt Backflow Device	2014	3,891		20	195	195	584	7
8	5 Ton Ac Unit	2014	2,850		20	143	143	428	8
9	Fire Alarm System & Control Panel	2014	9,520		20	476	476	1,428	9
10	51 Light Fixtures- Lighting, All Corridors	2014	12,980		20	649	649	1,947	10
11	Corridor Flooring Materials	2014	43,278		20	2,164	2,164	6,492	11
12	Corridors - Demolition/New Flooring/Drywall	2015	103,434		20	5,172	5,172	10,343	12
13	Door Alarm System	2015	18,615		20	931	931	1,862	13
14	Repair Fire Sprinkler For Shed	2016	9,721		20	486	486	486	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)		\$ 946,074	\$ 63,431		\$ 41,444	\$ (21,986)	\$ 405,060	34

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

Facility Name & ID Number Cedar Ridge Hlth & Rehab Ctr

0042838

Report Period Beginning:

01/01/16

Ending:

12/31/16

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 946,074	\$ 63,431		\$ 41,444	\$ (21,986)	\$ 405,060	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		\$ 946,074	\$ 63,431		\$ 41,444	\$ (21,986)	\$ 405,060	34

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

Facility Name & ID Number Cedar Ridge Hlth & Rehab Ctr

0042838

Report Period Beginning:

01/01/16

Ending:

12/31/16

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 946,074	\$ 63,431		\$ 41,444	\$ (21,986)	\$ 405,060	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)	\$ 946,074	\$ 63,431		\$ 41,444	\$ (21,986)	\$ 405,060	34

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

Facility Name & ID Number Cedar Ridge Hlth & Rehab Ctr

0042838

Report Period Beginning:

01/01/16

Ending:

12/31/16

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 946,074	\$ 63,431		\$ 41,444	\$ (21,986)	\$ 405,060	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)	\$ 946,074	\$ 63,431		\$ 41,444	\$ (21,986)	\$ 405,060	34

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

Facility Name & ID Number Cedar Ridge Hlth & Rehab Ctr

0042838

Report Period Beginning:

01/01/16

Ending:

12/31/16

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1 Building Company		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8 Leasehold Improvements:							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34 TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$

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

Facility Name & ID Number Cedar Ridge Hlth & Rehab Ctr

0042838

Report Period Beginning:

01/01/16

Ending:

12/31/16

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
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18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34		\$	\$		\$	\$	\$

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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)		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number Cedar Ridge Hlth & Rehab Ctr

0042838

Report Period Beginning:

01/01/16

Ending:

12/31/16

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
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22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34		\$	\$		\$	\$	\$

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 227,060	\$	\$ 19,369	\$ 19,369	10	\$ 141,838	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	364,487				10	364,487	73
74								74
75	TOTALS	\$ 591,548	\$	\$ 19,369	\$ 19,369		\$ 506,326	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		1999 Chevy Passenger Van	1999	\$ 35,966	\$	\$	\$	5	\$ 35,966	76
77		2005 Ford Van	2010	15,000				5	15,000	77
78		2012 Goshen Bus	2016	10,995		2,199	2,199	5	2,199	78
79										79
80	TOTALS			\$ 61,961	\$	\$ 2,199	\$ 2,199		\$ 53,165	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)	\$ 1,599,583	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 63,431	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 63,012	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (418)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 964,551	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Wentz Health Care

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:	<u>1986</u>	<u>116</u>		\$ <u>522,828</u>			<u>3</u>
4	Additions							<u>4</u>
5	Storage				<u>1,835</u>			<u>5</u>
6								<u>6</u>
7	TOTAL		<u>116</u>		\$ <u>524,663</u>			<u>7</u>

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2017 \$ _____

13. _____ /2018 \$ _____

14. _____ /2019 \$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 9,469

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	<u>Facility</u>	<u>Van</u>	\$ _____	\$ <u>10,212</u>	<u>17</u>
18					<u>18</u>
19					<u>19</u>
20					<u>20</u>
21	TOTAL		\$ -	\$ <u>10,212</u>	<u>21</u>

* 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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 272,146	\$		\$ 272,146	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			179,453			179,453	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			400,395			400,395	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				261,352		261,352	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					36,005	115,759		151,764	13
14	TOTAL			\$		\$ 887,999	\$ 377,111		\$ 1,265,110	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/16

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,000	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,168,723		3
4	Supply Inventory (priced at)	61,263		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,267		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	46,970		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,283,223	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,045,833		15
16	Equipment, at Historical Cost	656,503		16
17	Accumulated Depreciation (book methods)	(1,412,551)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	558,237		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 848,022	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,131,245	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 18,736	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	156,619		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	156,731		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 332,086	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 332,086	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,799,159	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,131,245	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,648,067	1
2	Restatements (describe):		2
3	Rounding	2	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,648,069	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	151,090	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 151,090	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,799,159	24 *

* This must agree with page 17, line 47.

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

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,597,019	1
2	Discounts and Allowances for all Levels	1,168,466	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,765,485	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	514,094	6
7	Oxygen	153	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 514,247	8
C. Other Operating Revenue			
9	Payments for Education	405	9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	27,206	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	75	19
20	Radiology and X-Ray		20
21	Other Medical Services	11,461	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 39,147	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	14,673	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 14,673	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,333,552	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	979,883	31
32	Health Care	2,863,712	32
33	General Administration	2,091,931	33
B. Capital Expense			
34	Ownership	695,013	34
C. Ancillary Expense			
35	Special Cost Centers	1,288,833	35
36	Provider Participation Fee	263,090	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,182,462	40
41	Income before Income Taxes (line 30 minus line 40)**	151,090	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 151,090	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 3,639,913	44
45	Private Pay - Net Inpatient Revenue	834,104	45
46	Medicare - Net Inpatient Revenue	2,212,409	46
47	Other-(specify) <u>Managed Care / HMO / Hospice</u>	821,325	47
48	Other-(specify) <u>Insurance / Veteran</u>	257,734	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,765,485	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.

Facility Name & ID Number Cedar Ridge Hlth & Rehab Ctr

0042838

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,929	2,131	\$ 100,754	\$ 47.29	1
2	Assistant Director of Nursing	780	864	25,141	29.09	2
3	Registered Nurses	11,933	13,389	348,266	26.01	3
4	Licensed Practical Nurses	32,619	36,100	830,294	23.00	4
5	CNAs & Orderlies	73,768	80,916	995,804	12.31	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,431	2,688	42,786	15.92	8
9	Activity Director	1,815	2,011	28,857	14.35	9
10	Activity Assistants	3,366	3,751	37,773	10.07	10
11	Social Service Workers	3,696	4,090	73,979	18.09	11
12	Dietician					12
13	Food Service Supervisor	2,022	2,208	43,965	19.91	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,445	16,888	174,549	10.34	15
16	Dishwashers					16
17	Maintenance Workers	3,760	4,126	73,635	17.85	17
18	Housekeepers	11,596	12,848	119,033	9.26	18
19	Laundry	5,686	6,220	60,205	9.68	19
20	Administrator	1,399	1,524	85,450	56.06	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,799	12,900	224,011	17.37	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	3,009	3,275	55,739	17.02	31
32	Other Health Care(specify)					32
33	Other(specify)	7,201	7,974	108,375	13.59	33
34	TOTAL (lines 1 - 33)	194,253	213,902	\$ 3,428,616 *	\$ 16.03	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	392	\$ 18,999	01-03	35
36	Medical Director	Monthly	12,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	22	1,272	10-03	38
39	Pharmacist Consultant	Monthly	8,573	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	28	1,735	11-03	44
45	Social Service Consultant	28	1,735	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	470	\$ 44,314		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Michael Altobella	Administrator	0	\$ 34,259	Workers' Compensation Insurance	\$ 78,767	IDPH License Fee	\$ 2,239		
Harold Lutz	Administrator	0	51,191	Unemployment Compensation Insurance	68,067	Advertising: Employee Recruitment	10,803		
				FICA Taxes	254,411	Health Care Worker Background Check (Indicate # of checks performed _____)			
				Employee Health Insurance	208,624	Patient Background Checks			
				Employee Meals		Dues and Subscriptions	5,303		
				Illinois Municipal Retirement Fund (IMRF)*		License and Permits	1,207		
				Vision Insurance	31	Allocated from Covenant Care California, LL	1,485		
				Life Insurance	2,884				
				Dental Insurance	294				
				Other Employee Benefits	23,668	Less: Public Relations Expense ()			
				Holiday Fund Budget	1,044	Non-allowable advertising ()			
						Yellow page advertising ()			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 85,450	TOTAL (agree to Schedule V, line 22, col.8)		\$ 637,788	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 21,036
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Management Fees - Covenant Care California, LLC			\$ 449,128				Out-of-State Travel	\$	
							In-State Travel		
							Seminar Expense	706	
							Allocated from Covenant Care California, LL	33,954	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 449,128	TOTAL		\$	Entertainment Expense ()		
C. Professional Services									
Vendor/Payee	Type		Amount						
See Attached	Legal		\$ 18,420						
Ability Network	Data Processing		819						
HealthLink	Data Processing		2,065						
Home Instead Senior Care	In-Care Home		1,423						
Living Design Inc.	Design Consultant		127						
MPRO	Medical Consulting		540						
National Datacare Corporation	Data Processing		2,948						
Nova Voice and Data Systems	Telecommunications		268						
Pinnacle Quality Insight	Customer Satisfaciton		2,268						
Saric Consulting	Resident Consultant		3,323						
SmartLinx Solutions	Labor Management Software		4,913						
See Supplemental Schedule			32,863						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 69,978				TOTAL (agree to Sch. V, line 24, col. 8)		\$ 34,660

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Cedar Ridge Hlth & Rehab Ctr

0042838

Report Period Beginning:

01/01/16

Ending:

12/31/16

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? Yes
If YES, give association name and amount. AHCA, IHCA \$7,656
- (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. \$ 46,647 Line 10-02
- (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? X YES 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. \$ 263,090
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 benefit on Schedule V. \$ No 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 14
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (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