

Facility Name & ID Number Jacksonville Skl Nur & Rehab

0051433 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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>61</u>	Skilled (SNF)	<u>61</u>	<u>22,265</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>27</u>	Intermediate (ICF)	<u>27</u>	<u>9,855</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>88</u>	TOTALS	<u>88</u>	<u>32,120</u>	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	<u>8,061</u>	<u>5,201</u>	<u>5,017</u>	<u>18,279</u>	8
9	SNF/PED					9
10	ICF	<u>5,406</u>	<u>3,116</u>	<u>862</u>	<u>9,384</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>13,467</u>	<u>8,317</u>	<u>5,879</u>	<u>27,663</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.12%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 61 and days of care provided 3,522

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES 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 Jacksonville Ski Nur & Rehab # 0051433 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				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	174,712	10,698	10,760	196,170	0	196,170	0	196,170		1
2	Food Purchase		148,883		148,883	0	148,883	0	148,883		2
3	Housekeeping	90,283	13,968	5,424	109,675	0	109,675	0	109,675		3
4	Laundry	36,069	7,055	75	43,199	0	43,199	0	43,199		4
5	Heat and Other Utilities			71,885	71,885	0	71,885	0	71,885		5
6	Maintenance	36,814	7,622	25,617	70,053	0	70,053	0	70,053		6
7	Other (specify):* Trash Removal	0	0	8,080	8,080	0	8,080	0	8,080		7
8	TOTAL General Services	337,878	188,226	121,841	647,945	0	647,945	0	647,945		8
	B. Health Care and Programs										
9	Medical Director	0	0	17,056	17,056	0	17,056	0	17,056		9
10	Nursing and Medical Records	1,844,386	84,989	69,122	1,998,497	0	1,998,497	0	1,998,497		10
10a	Therapy	0	0	668,733	668,733	0	668,733	0	668,733		10a
11	Activities	69,370	1,455	3,893	74,718	0	74,718	0	74,718		11
12	Social Services	109,524	0	3,667	113,191	0	113,191	0	113,191		12
13	CNA Training	56,534	0	0	56,534	0	56,534	0	56,534		13
14	Program Transportation	0	0	9,825	9,825	0	9,825	0	9,825		14
15	Other (specify):* H.O. Direct Care	0	0	0	0	0	0	31,223	31,223		15
16	TOTAL Health Care and Programs	2,079,814	86,444	772,296	2,938,554	0	2,938,554	31,223	2,969,777		16
	C. General Administration										
17	Administrative	30,521	0	310,324	340,845	0	340,845	52,741	393,586		17
18	Directors Fees			0	0	0	0	0	0		18
19	Professional Services			107,755	107,755	0	107,755	(707)	107,048		19
20	Dues, Fees, Subscriptions & Promotions			38,306	38,306	0	38,306	(1,726)	36,580		20
21	Clerical & General Office Expenses	72,841	67,897	156,875	297,613	0	297,613	(165,150)	132,463		21
22	Employee Benefits & Payroll Taxes			431,852	431,852	0	431,852	(881)	430,971		22
23	Inservice Training & Education			0	0	0	0	0	0		23
24	Travel and Seminar			871	871	0	871	0	871		24
25	Other Admin. Staff Transportation		0	115	115	0	115	0	115		25
26	Insurance-Prop.Liab.Malpractice			164,150	164,150	0	164,150	0	164,150		26
27	Other (specify):* Contract Admin	5,156	0	125,314	130,470	0	130,470	(20,013)	110,457		27
28	TOTAL General Administration	108,518	67,897	1,335,562	1,511,977	0	1,511,977	(135,736)	1,376,241		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,526,210	342,567	2,229,699	5,098,476	0	5,098,476	(104,513)	4,993,963		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 **Jacksonville Skl Nur & Rehab**

#0051433

Report Period Beginning:

01/01/18

Ending:

12/31/18

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			134,220	134,220	0	134,220	119,196	253,416		30
31	Amortization of Pre-Op. & Org.			0	0	0	0	0	0		31
32	Interest			0	0	0	0	17,694	17,694		32
33	Real Estate Taxes			38,020	38,020	0	38,020	1,525	39,545		33
34	Rent-Facility & Grounds			281,408	281,408	0	281,408	(281,408)	0		34
35	Rent-Equipment & Vehicles			29,764	29,764	0	29,764	0	29,764		35
36	Other (specify):* Business Taxes			245	245	0	245	(245)	0		36
37	TOTAL Ownership			483,657	483,657	0	483,657	(143,238)	340,419		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0		38
39	Ancillary Service Centers	0	18,937	164,795	183,732	0	183,732	0	183,732		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	194,224	194,224	0	194,224	0	194,224		42
43	Other (specify):*	0	0	0	0	0	0	0	0		43
44	TOTAL Special Cost Centers	0	18,937	359,019	377,956	0	377,956	0	377,956		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,526,210	361,504	3,072,375	5,960,089	0	5,960,089	(247,751)	5,712,338		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	\$ 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	(10,353)	32		10
11	Discounts, Allowances, Rebates & Refunds	0			11
12	Non-Working Officer's or Owner's Salary	0			12
13	Sales Tax	0			13
14	Non-Care Related Interest	0			14
15	Non-Care Related Owner's Transactions	0			15
16	Personal Expenses (Including Transportation)	0			16
17	Non-Care Related Fees	0			17
18	Fines and Penalties	0			18
19	Entertainment	0			19
20	Contributions	0			20
21	Owner or Key-Man Insurance	0			21
22	Special Legal Fees & Legal Retainer	0			22
23	Malpractice Insurance for Individuals	0			23
24	Bad Debt	(122,437)	21		24
25	Fund Raising, Advertising and Promotional	(20,013)	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	(44,747)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (197,550)		\$ 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	2	
		Amount	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)	(50,201)	VII-B	34
35	Other- Attach Schedule	0		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (50,201)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (247,751)		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)			\$ 0		47

Jacksonville Skl Nur & Rehab

ID# 0051433

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)	(881)	22	2
3	Bank Charges	(3,320)	21	3
4	Business Taxes	(245)	36	4
5	Patient Theft and Loss	(795)	21	5
6	Prior Year Expense	(38,598)	21	6
7	Nonallowable PAC Dues	(1,726)	20	7
8	Nonallowable Legal Fees	(707)	19	8
9	Real Estate Tax Accrual	1,525	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	(44,747)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Jacksonville Skl Nur & Rehab

0051433

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 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)	
	A. General Services													
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	31,223	0	0	0	0	0	0	0	31,223	15
16	TOTAL Health Care and Programs	0	0	0	31,223	0	0	0	0	0	0	0	31,223	16
	C. General Administration													
17	Administrative	0	0	0	52,741	0	0	0	0	0	0	0	52,741	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(707)	0	0	0	0	0	0	0	0	0	0	(707)	19
20	Fees, Subscriptions & Promotions	(1,726)	0	0	0	0	0	0	0	0	0	0	(1,726)	20
21	Clerical & General Office Expenses	(165,150)	0	0	0	0	0	0	0	0	0	0	(165,150)	21
22	Employee Benefits & Payroll Taxes	(881)	0	0	0	0	0	0	0	0	0	0	(881)	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 &	(20,013)	0	0	0	0	0	0	0	0	0	0	(20,013)	27
28	TOTAL General Administration	(188,477)	0	0	52,741	0	0	0	0	0	0	0	(135,736)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(188,477)	0	0	83,964	0	0	0	0	0	0	0	(104,513)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Jacksonville Skl Nur & Rehab # 0051433 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	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)	
	D. Ownership													
30	Depreciation	0	80,221	0	38,975	0	0	0	0	0	0	0	119,196	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10,353)	0	0	28,047	0	0	0	0	0	0	0	17,694	32
33	Real Estate Taxes	1,525	0	0	0	0	0	0	0	0	0	0	1,525	33
34	Rent-Facility & Grounds	0	(281,408)	0	0	0	0	0	0	0	0	0	(281,408)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):* BUSINESS TAX	(245)	0	0	0	0	0	0	0	0	0	0	(245)	36
37	TOTAL Ownership	(9,073)	(201,187)	0	67,022	0	(143,238)	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)	(197,550)	(201,187)	0	150,986	0	(247,751)	45						

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 281,408	CC Jacksonville Holding, LLC	100.00%	\$	\$(281,408)	1
2	V	30 Depreciation		CC Jacksonville Holding, LLC	100.00%	80,221	80,221	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		\$ 281,408			\$ 80,221	\$ * (201,187)	14

* Total must agree with the amount recorded on line 34 of Schedule V1.

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 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
		Item	Amount	Name of Related Organization						
15	V	10a	Physical Therapy	\$ 244,430		100.00%	\$ 244,502	\$	72	15
16	V	10a	Occupational Therapy	278,265		100.00%	278,218	\$	(47)	16
17	V	10a	Speech Therapy	146,038		100.00%	146,013	\$	(25)	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			\$ 668,733			\$ 668,733	\$ *	0	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	43 NonAllow	\$	Covenant Care California, LLC	100.00%	\$	\$	15
16	V	15 Direct		Covenant Care California, LLC	100.00%	31,223	31,223	16
17	V	17 Indirect		Covenant Care California, LLC	100.00%	363,065	363,065	17
18	V	32 Interest		Covenant Care California, LLC	100.00%	28,047	28,047	18
19	V	30 Depreciation		Covenant Care California, LLC	100.00%	38,975	38,975	19
20	V	17 Management Fees	310,324	Covenant Care California, LLC	100.00%		(310,324)	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		\$ 310,324			\$ 461,310	\$ * 150,986	39

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

Facility Name & ID Number

Jacksonville Skl Nur & Rehab

0051433

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 &	CALIFORNIA	CC JACKSONVILLE	JACKSONVILLE, IL	BUILDING CO.	3
4			CARSON NURSING & REHAB CENTER	NEVADA				4
5			CATERED MANOR	CALIFORNIA				5
6			CLINTON HOUSE HEALTH & REHABILITATI	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 REHABILITATI	CALIFORNIA				18
19			ENNOBLE SKILLED NURSING & REHAB CE	IOWA				19
20			FAIRVIEW MANOR NURSING CENTER	OHIO				20
21			FRIENDSHIP HOME	CARLINVILLE, IL				21
22			GILROY HEALTHCARE & 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 & REHABILITATI	CALIFORNIA				28
29			MISSION SKILLED NURSING & SUBACUTE	CALIFORNIA				29
30			NEBRASKA SKILLED NURSING CENTER	NEBRASKA				30

Facility Name & ID Number

Jacksonville Skl Nur & Rehab

0051433

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 & REHABILITATION	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 (VILLAGE)	OHIO				25
26			MARION REHAB AND ASSISTED LIVING CENTER	INDIANA				26
27			PYRAMID POINT POST ACUTE REHABILITATION	INDIANA				27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1									\$	1
2										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 Jacksonville Skl Nur & Rehab # 0051433 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

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

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					\$	\$		\$	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 Jacksonville Skl Nur & Rehab # 0051433 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

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	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		\$	\$		\$ 244,430	1
2	39	Occupational Therapy	Direct Allocation					278,265	2
3	39	Speech Therapy	Direct Allocation					146,038	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				\$	\$		\$ 668,733	25

Facility Name & ID Number Jacksonville Skl Nur & Rehab # 0051433 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

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

Name of Related Organization Covenant Care California, LLC
 Street Address Aliso Creek Road
 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	43	NonAllow	Accumulated Cost		\$	\$		\$	1
2	15	Direct	Accumulated Cost					31,223	2
3	17	Indirect	Accumulated Cost					363,065	3
4	32	Interest	Accumulated Cost					28,047	4
5	30	Depreciation	Accumulated Cost					38,975	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				\$	\$		\$	461,310

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1																				
2																				
3																				
4																				
5																				
Working Capital																				
6	Allocated from Covenant Care,	X								28,047										
7																				
8																				
9	TOTAL Facility Related					\$ 0	\$ 0			\$ 28,047										
B. Non-Facility Related*																				
10	Interest Income		X							(10,353)										
11																				
12																				
13																				
14	TOTAL Non-Facility Related					\$ 0	\$ 0			\$ (10,353)										
15	TOTALS (line 9+line14)					\$ 0	\$ 0			\$ 17,694										

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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1.	Real Estate Tax accrual used on 2017 report.	\$	37,255	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.)	\$	38,780	2	
3.	Under or (over) accrual (line 2 minus line 1).	\$	1,525	3	
4.	Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	38,020	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	\$	39,545	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2013	<u>34,717</u>	8	
		2014	<u>35,828</u>	9	
		2015	<u>36,801</u>	10	
		2016	<u>37,255</u>	11	
		2017	<u>38,780</u>	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 Jacksonville Skl Nur & Rehab COUNTY Morgan

FACILITY IDPH LICENSE NUMBER 0051433

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)	(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>09-18-301-002</u>	<u>Long Term Care Property</u>	\$ <u>38,780.30</u>	\$ <u>38,780.30</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>38,780.30</u></u>	\$ <u><u>38,780.30</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 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 Jacksonville Skl Nur & Rehab

0051433

Report Period Beginning:

01/01/18

Ending:

12/31/18

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,061 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

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

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

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

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

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

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9
FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	88	2015	1,929,283		35			
5								
6								
7								
8								
Improvement Type**								
9	Various	2011	30,425		20			
10	Various	2012	419,670		20			
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
31								
32								
33								
34								
35								
36								

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	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			64,309		64,309		225,083	67
68			38,975		38,975			68
69			91,882		91,882			69
70		\$ 2,379,378	\$ 195,166		\$ 195,166	\$ 0	\$ 225,083	70

**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	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	\$ 2,379,378	\$ 195,166		\$ 195,166		\$ 225,083		1
2	Installed New Water Heater & Circulator Pump	2013 6,850	343	20	343		1,713		2
3	Installed Trunk Line With New Circuits	2013 3,458	173	20	173		865		3
4	Fire Sprinkler Repair	2013 9,657	483	20	483		2,414		4
5	Storage Shed 10 X 16	2014 3,037	152	20	152		607		5
6	Shower, Closet Doors, Corridor S. Hall Rms 113-122:	2014		20					6
7	Replace Tiles & Mirrors, Repaint Walls, Plumbing	2014 101,490	5,074	20	5,074		20,296		7
8	Shower, Closet Doors, Corridor S. Hall Rms 113-122:	2014		20	0		0		8
9	Replace Tiles & Mirrors, Repaint Walls, Plumbing	2014 11,277	564	20	564		2,256		9
10	Water Heater	2015 11,595	580	20	580		1,740		10
11	Drywall/Painting, Replace Ceiling Tile/Lighting In West Hall	2015 27,671	1,384	20	1,384		4,151		11
12	Code Alert Doors	2015 16,690	835	20	835		2,504		12
13	Demolition, Wall Skimming & Paint, Electrical, Act Ceiling--	2016 114,827	5,741	20	5,741		11,482		13
14	--Tile, Closet Doors, Carpet, Vct Additions, Roofing/Asphalt	2016		20					14
15	Garbage Disposal	2017 1,122		7					15
16	GE PTAC Unit	2017 799	38	7	38		38		16
17	Refrigerator	2018 4,429		5					17
18	Three section Refrigerator	2018 4,332		5					18
19	Accumulated Depreciation and Depreciation	2018	11,993		11,993		412,532		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)	\$ 2,696,611	\$ 222,526		\$ 222,526	\$ 0	\$ 685,681		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	\$ 190,981	\$ 30,380	\$ 30,380	\$ 0		\$ 207,454	71
72	Current Year Purchases				0			72
73	Fully Depreciated Assets	175,489			0		175,489	73
74					0			74
75	TOTALS	\$ 366,470	\$ 30,380	\$ 30,380	\$ 0		\$ 382,943	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	7	\$ 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)	\$ 3,073,796	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 253,416	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 253,416	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)	\$ 1,070,665	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
 If NO, see instructions. 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>281,408</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ <u>281,408</u>			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. <u>/2018</u>	\$ _____
13. <u>/2019</u>	\$ _____
14. <u>/2020</u>	\$ _____

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: \$ 29,764 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>N/A</u>		\$ _____	\$ _____	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.

Page 14 Supplemental

Company	Locn	Dept	Account	Journal_Des	Amount	Month	Year	JournalNuml	ApplyDate
CCMIDWST	072	6110	60000620	MEMORIAL F	83.65		1	2018 JRN0019264	01/31/18
CCMIDWST	072	6110	60000620	MEMORIAL F	221.19		3	2018 JRN0019425	03/31/18
CCMIDWST	072	6110	60000620	MEMORIAL F	36.65		4	2018 JRN0019497	04/30/18
CCMIDWST	072	6110	60000620	MEMORIAL F	748		10	2018 JRN0019982	10/31/18
CCMIDWST	072	6110	60000620	Rcl Jun SMS f	297.88		6	2018 JRN0019705	06/30/18
CCMIDWST	072	6500	60000620	ECOLAB - 07;	144.22		1	2018 JRN0019237	01/31/18
CCMIDWST	072	6500	60000620	ECOLAB - 07;	144.22		2	2018 JRN0019341	02/28/18
CCMIDWST	072	6500	60000620	ECOLAB - 07;	144.22		3	2018 JRN0019425	03/31/18
CCMIDWST	072	6500	60000620	ECOLAB - 07;	144.22		5	2018 JRN0019551	05/25/18
CCMIDWST	072	6500	60000620	ECOLAB - 07;	144.22		6	2018 JRN0019622	06/18/18
CCMIDWST	072	6500	60000620	ECOLAB - 07;	144.22		7	2018 JRN0019699	07/11/18
CCMIDWST	072	6500	60000620	ECOLAB - 07;	144.22		8	2018 JRN0019806	08/17/18
CCMIDWST	072	6500	60000620	ECOLAB - 07;	144.22		10	2018 JRN0019951	10/17/18
CCMIDWST	072	6500	60000620	ECOLAB - 07;	144.22		11	2018 JRN0020071	11/30/18
CCMIDWST	072	6901	60000620	Acc est HPFS	259		11	2018 JRN0020071	11/30/18
CCMIDWST	072	6901	60000620	Acc est HPFS	-259		12	2018 JRN0020094	12/31/18
CCMIDWST	072	6901	60000620	Acc HPFS sch	258.76		12	2018 JRN0020121	12/31/18
CCMIDWST	072	6901	60000620	Acc Konica N	139.7		3	2018 JRN0019461	03/31/18
CCMIDWST	072	6901	60000620	Acc Konica N	244.94		3	2018 JRN0019461	03/31/18
CCMIDWST	072	6901	60000620	Acc Konica N	-139.7		4	2018 JRN0019485	04/30/18
CCMIDWST	072	6901	60000620	Acc Konica N	-244.94		4	2018 JRN0019485	04/30/18
CCMIDWST	072	6901	60000620	HEWLETT-PA	258.76		10	2018 JRN0019982	10/31/18
CCMIDWST	072	6901	60000620	HEWLETT-PA	258.76		10	2018 JRN0019982	10/31/18
CCMIDWST	072	6901	60000620	HEWLETT-PA	258.76		10	2018 JRN0020024	10/31/18
CCMIDWST	072	6901	60000620	HEWLETT-PA	258.76		12	2018 JRN0020085	12/24/18
CCMIDWST	072	6901	60000620	KONICA MIN	159.24		1	2018 JRN0019201	01/17/18
CCMIDWST	072	6901	60000620	KONICA MIN	272.33		1	2018 JRN0019201	01/17/18
CCMIDWST	072	6901	60000620	KONICA MIN	384.64		2	2018 JRN0019305	02/28/18
CCMIDWST	072	6901	60000620	KONICA MIN	139.7		4	2018 JRN0019444	04/14/18
CCMIDWST	072	6901	60000620	KONICA MIN	244.94		4	2018 JRN0019444	04/14/18
CCMIDWST	072	6901	60000620	KONICA MIN	139.7		5	2018 JRN0019534	05/17/18
CCMIDWST	072	6901	60000620	KONICA MIN	244.94		5	2018 JRN0019534	05/17/18
CCMIDWST	072	6901	60000620	KONICA MIN	139.7		6	2018 JRN0019635	06/22/18
CCMIDWST	072	6901	60000620	KONICA MIN	244.94		6	2018 JRN0019635	06/22/18
CCMIDWST	072	6901	60000620	PETTY CASH	42.19		4	2018 JRN0019454	04/19/18
CCMIDWST	072	8131	60000620	Acc 10/18 IS\	465		10	2018 JRN0020008	10/31/18
CCMIDWST	072	8131	60000620	Acc 10/18 IS\	-465		11	2018 JRN0020041	11/30/18
CCMIDWST	072	8131	60000620	Acc 11/18 IS\	450		11	2018 JRN0020051	11/30/18
CCMIDWST	072	8131	60000620	Acc 11/18 IS\	-450		12	2018 JRN0020094	12/31/18
CCMIDWST	072	8131	60000620	Acc 12/17 IS\	-336		1	2018 JRN0019251	01/31/18
CCMIDWST	072	8131	60000620	Acc 12/18 IS\	465		12	2018 JRN0020101	12/31/18
CCMIDWST	072	8131	60000620	Acc 6/18 ISV	525		6	2018 JRN0019674	06/30/18
CCMIDWST	072	8131	60000620	Acc 6/18 ISV	-525		7	2018 JRN0019731	07/31/18
CCMIDWST	072	8131	60000620	Acc 7/18 Joe	542.5		7	2018 JRN0019755	07/31/18
CCMIDWST	072	8131	60000620	Acc 7/18 Joe	-542.5		8	2018 JRN0019827	08/31/18
CCMIDWST	072	8131	60000620	Acc 8/18 ISV	537.5		8	2018 JRN0019844	08/31/18
CCMIDWST	072	8131	60000620	Acc 8/18 ISV	-537.5		9	2018 JRN0019909	09/30/18
CCMIDWST	072	8131	60000620	Acc 9/18 ISV	450		9	2018 JRN0019920	09/30/18
CCMIDWST	072	8131	60000620	Acc 9/18 ISV	-450		10	2018 JRN0019961	10/31/18
CCMIDWST	072	8131	60000620	CR- Joerns 2C	-31.5		11	2018 JRN0020061	11/30/18
CCMIDWST	072	8131	60000620	CR- Joerns 4C	-211.89		2	2018 JRN0019371	02/28/18
CCMIDWST	072	8131	60000620	CR-SMS Q2/J	-16.4		9	2018 JRN0019930	09/30/18
CCMIDWST	072	8131	60000620	CR-SMS Q4/J	-13.23		1	2018 JRN0019261	01/31/18
CCMIDWST	072	8131	60000620	ISAVE - JOER	336		1	2018 JRN0019221	01/08/18
CCMIDWST	072	8131	60000620	ISAVE - JOER	525		7	2018 JRN0019696	07/09/18
CCMIDWST	072	8131	60000620	ISAVE - JOER	542.5		8	2018 JRN0019808	08/13/18
CCMIDWST	072	8131	60000620	ISAVE - JOER	537.5		9	2018 JRN0019871	09/10/18
CCMIDWST	072	8131	60000620	ISAVE - JOER	450		10	2018 JRN0019971	10/08/18
CCMIDWST	072	8131	60000620	ISAVE - JOER	465		11	2018 JRN0020031	11/12/18
CCMIDWST	072	8131	60000620	ISAVE - JOER	450		12	2018 JRN0020071	12/10/18
CCMIDWST	072	8131	60000620	Rcl Jun SMS f	-297.88		6	2018 JRN0019705	06/30/18
CCMIDWST	072	8131	60000620	SPECIALIZED	424.86		6	2018 JRN0019658	06/30/18
CCMIDWST	072	8200	60000620	ACCELERATE	1707		1	2018 JRN0019220	01/25/18
CCMIDWST	072	8200	60000620	ACCELERATE	1707		2	2018 JRN0019301	02/25/18
CCMIDWST	072	8200	60000620	ACCELERATE	1707		3	2018 JRN0019380	03/25/18
CCMIDWST	072	8200	60000620	ACCELERATE	1707		4	2018 JRN0019464	04/25/18
CCMIDWST	072	8200	60000620	ACCELERATE	1707		5	2018 JRN0019551	05/25/18
CCMIDWST	072	8200	60000620	ACCELERATE	1707		6	2018 JRN0019635	06/25/18
CCMIDWST	072	8200	60000620	ACCELERATE	1707		7	2018 JRN0019731	07/25/18
CCMIDWST	072	8200	60000620	ACCELERATE	1707		8	2018 JRN0019814	08/25/18
CCMIDWST	072	8200	60000620	ACCELERATE	1707		9	2018 JRN0019899	09/25/18
CCMIDWST	072	8200	60000620	ACCELERATE	1707		10	2018 JRN0019961	10/25/18
CCMIDWST	072	8200	60000620	ACCELERATE	1707		11	2018 JRN0020031	11/25/18
CCMIDWST	072	8200	60000620	ACCELERATE	1707		12	2018 JRN0020091	12/25/18

29,764.43

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	\$	\$	\$	\$ 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.)

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	V10A	0.00	hrs	\$ 0	5,430	\$ 278,265	\$ 0	5,430	\$ 278,265	1	
2	Licensed Speech and Language Development Therapist	V10A	0.00	hrs	0	4,082	146,038	0	4,082	146,038	2	
3	Licensed Recreational Therapist	V10A	0.00	hrs	0	0	0	0			3	
4	Licensed Physical Therapist	V10A	0.00	hrs	0	4,499	244,430	0	4,499	244,430	4	
5	Physician Care			visits							5	
6	Dental Care			visits							6	
7	Work Related Program			hrs							7	
8	Habilitation	V39	0.00	hrs	0	0	0	6,768		6,768	8	
9	Pharmacy	V39	0.00	# of prescrpts	0	0	0	126,560		126,560	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10	
11	Academic Education			hrs							11	
12	Other (specify): <u>LAB/RADIOLOGY</u>	V39	0.00		0	0	0	32,977		32,977	12	
13	Other (specify): <u>BILLABLE SUPPLIES</u>	V39	0.00		0	0	0	17,427		17,427	13	
14	TOTAL				\$	14,011	\$ 668,733	\$ 183,732	14,011	\$ 852,465	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 Jacksonville Skl Nur & Rehab
 XV. BALANCE SHEET - Unrestricted Operating Fund.

0051433
 As of 12/31/18

Report Period Beginning: 01/01/18
 (last day of reporting year)

Ending: 12/31/18

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

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,000	\$ 1,000 1
2	Cash-Patient Deposits	0	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 450,081)	1,516,561	1,516,561 3
4	Supply Inventory (priced at)	37,444	37,444 4
5	Short-Term Investments	0	5
6	Prepaid Insurance	0	6
7	Other Prepaid Expenses	1,327	1,327 7
8	Accounts Receivable (owners or related parties)	0	8
9	Other(specify): <u>Inventories</u>	7,296	7,296 9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,563,628	\$ 1,563,628 10
B. Long-Term Assets			
11	Long-Term Notes Receivable	0	11
12	Long-Term Investments	190,939	190,939 12
13	Land	0	13
14	Buildings, at Historical Cost	0	1,929,283 14
15	Leasehold Improvements, at Historical Cos	767,328	767,328 15
16	Equipment, at Historical Cost	297,627	377,185 16
17	Accumulated Depreciation (book methods)	(789,892)	(1,070,665) 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): <u>Cost Settlement Medicare</u>	39,000	39,000 23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 505,002	\$ 2,233,070 24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,068,630	\$ 3,796,698 25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26	Accounts Payable	\$ 2,095	\$ 2,095 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	136,120	136,120 30
31	Accrued Taxes Payable (excluding real estate taxes)	30	30 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	<u>Medicaid Cost Settlement</u>	(206)	(206) 36
37	<u>Intercompany</u>	(3,805,304)	(2,617,643) 37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ (3,667,265)	\$ (2,479,604) 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	<u>Deferred Liabilities</u>	(134,195)	(134,195) 43
44		0	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ (134,195)	\$ (134,195) 45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ (3,801,460)	\$ (2,613,799) 46
47	TOTAL EQUITY(page 18, line 24)	\$ 5,870,090	\$ 6,410,497 47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,068,630	\$ 3,796,698 48

*(See instructions.)

General Ledger Detail
02/27/18
01:15 PM

Mid West SNF/RES
073-CC Jacksonville Holding, LLC (#072)
For the Twelve Months Ending December 31, 2017

1

Acct Number	Dept	Account	Description	YTD
073-0000-12210000	0000	12210000	BLDG & IMPV - FACILITY BUILDINGS	1,929,283
073-0000-12410000	0000	12410000	EQUIP - MAJOR MOVABLE	79,558
073-0000-12710000	0000	12710000	ACC DEPR - FACILITY BUILDINGS	(225,083)
073-0000-12910000	0000	12910000	ACC DEPR - MAJOR MOVABLE EQUIP	(55,691)
073-0000-20800099	0000	20800099	INTERCOMPANY	(1,187,661)
073-0000-24400100	0000	24400100	EQUITY - RETAINED EARNINGS	(523,527)
073-0000-29990000	0000	29990000	CURRENT YEAR PROFIT/LOSS	184,307
073-7100-70009220	7100	70009220	PROPERTY DEPR-BLDGS & IMPROVEMENTS	64,309
073-7100-70009240	7100	70009240	PROPERTY DEPR-MAJOR MOVABLE EQUIP	15,912
073-8000-40003430	8000	40003430	MISC. REV. RENT INCOME	(281,408)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,629,920	1
2	Restatements (describe):		2
3	Prior Period Adj.	(38,519)	3
4	0	0	4
5	0	0	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,591,401	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	278,689	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)	\$ 278,689	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)	\$ 5,870,090	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.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,187,811	1
2	Discounts and Allowances for all Levels	(1,512,499)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,675,312	3
B. Ancillary Revenue			
4	Day Care	0	4
5	Other Care for Outpatients	0	5
6	Therapy	2,379,319	6
7	Oxygen	0	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,379,319	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 Radic	0	15
16	Rental of Facility Space	0	16
17	Sale of Drugs	127,635	17
18	Sale of Supplies to Non-Patients	0	18
19	Laboratory	26,889	19
20	Radiology and X-Ray	6,950	20
21	Other Medical Services	12,320	21
22	Laundry	0	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 173,794	23
D. Non-Operating Revenue			
24	Contributions	0	24
25	Interest and Other Investment Income***	10,353	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10,353	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)	\$ 6,238,778	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	647,945	31
32	Health Care	2,938,554	32
33	General Administration	1,511,977	33
B. Capital Expense			
34	Ownership	483,657	34
C. Ancillary Expense			
35	Special Cost Centers	183,732	35
36	Provider Participation Fee	194,224	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)*	\$ 5,960,089	40
41	Income before Income Taxes (line 30 minus line 40)**	278,689	41
42	Income Taxes	0	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 278,689	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,996,643	44
45	Private Pay - Net Inpatient Revenue	1,570,367	45
46	Medicare - Net Inpatient Revenue	1,744,048	46
47	Other-(specify) ALL OTHER SNF/SCF IP REVENUE	416,466	47
48	Other-(specify) C/A ANCILLARY ACCOUNTS	(2,052,212)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,675,312	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 Jacksonville Skl Nur & Rehab

0051433

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	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,553	1,569	\$ 90,858	\$ 57.91	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	5,752	7,601	192,022	25.26	3
4	Licensed Practical Nurses	20,661	20,661	580,616	28.10	4
5	CNAs & Orderlies	52,216	52,216	821,672	15.74	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	1,854	1,854	26,091	14.07	9
10	Activity Assistants	3,668	3,801	43,279	11.39	10
11	Social Service Workers	4,897	5,008	109,524	21.87	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	2,099	2,099	37,483	17.86	13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	12,838	12,990	137,230	10.56	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	1,937	2,046	36,814	17.99	17
18	Housekeepers	7,758	7,881	90,283	11.46	18
19	Laundry	3,555	3,576	36,069	10.09	19
20	Administrator	714	728	30,521	41.92	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	0	0	0		22
23	Office Manager	0	0	0		23
24	Clerical	4,979	5,137	72,841	14.18	24
25	Vocational Instruction	1,888	1,888	56,534	29.94	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	2,126	2,166	65,777	30.37	31
32	Other Health Care(specify)	3,184	3,184	93,441	29.35	32
33	Other(specify) Marketing	134	136	5,154	37.90	33
34	TOTAL (lines 1 - 33)	131,813	134,541	\$ 2,526,209 *	\$ 18.78	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	0	\$ 10,760	01-03	35
36	Medical Director	0	12,000	09-03	36
37	Medical Records Consultant	0	1,345	10-03	37
38	Nurse Consultant	0	0		38
39	Pharmacist Consultant	0	7,716	10-03	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	3,668	11-03	44
45	Social Service Consultant	0	3,667	12-03	45
46	Other(specify)	0	0		46
47		0	0		47
48		0	0		48
49	TOTAL (lines 35 - 48)		\$ 39,157		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	657	\$ 46,071	10-03	50
51	Licensed Practical Nurses	31	1,488	10-03	51
52	Certified Nurse Assistants/Aides	81	7,508	10-03	52
53	TOTAL (lines 50 - 52)	769	\$ 55,067		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		
Miranda Witt		0	\$ 7,846	Workers' Compensation Insurance	\$ 51,975	IDPH License Fee	\$ 1,990		
Chastity Harris		0	22,675	Unemployment Compensation Insurance		Advertising: Employee Recruitment	29,065		
				FICA Taxes	221,358	Health Care Worker Background Check (Indicate # of checks performed _____)			
				Employee Health Insurance	150,131	Patient Background Checks			
				Employee Meals		Dues & Subscriptions	5,525		
				Illinois Municipal Retirement Fund (IMRF)*					
				Dental Insurance	720				
				Vision Insurance	31				
				Other Employee Benefits	3,479				
				Group Life & Disability	1,745				
				Employee Physicals/X-Ray	1,532				
						Less: Public Relations Expense	()		
						Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)					\$ 30,521	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 36,580	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description				Description	Line #	Amount	Description	Amount	
Management Fees - Covenant Care California, LLC							Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			Seminar Expense		871
							Entertainment Expense	()	
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)						\$	TOTAL	\$ 871	

* Attach copy of IMRF notifications

**See instructions.

PAGE 21 SUPPLEMENTAL - LEGAL FEE DETAIL

Company	Locn	Dept	Account	Journal_Description	Amount	Month	Year	JournalNumber	ApplyDate	Purpose	(Non)Allowable
CCMIDWST	072	6901	60000470	Acr Sandberg 11/17	(27.50)	1	2018	JRNL00191887	01/31/18	Collection	NonAllowable
CCMIDWST	072	6901	60000470	Acr Sandberg 11/17	27.50	1	2018	JRNL00192447	01/31/18	Collection	NonAllowable
CCMIDWST	072	6901	60000470	Acr Sandberg 11/17	(27.50)	2	2018	JRNL00192669	02/28/18	Collection	NonAllowable
CCMIDWST	072	6901	60000470	Acr Sandberg Phoenix 12/18	260.19	12	2018	JRNL00201137	12/31/18	Regulatory	Allowable
CCMIDWST	072	6901	60000470	Acr Sandberg Phoenix 2/18	536.45	2	2018	JRNL00193483	02/28/18	Regulatory	Allowable
CCMIDWST	072	6901	60000470	Acr Sandberg Phoenix 2/18	(536.45)	3	2018	JRNL00193579	03/31/18	Regulatory	Allowable
CCMIDWST	072	6901	60000470	Acr Sandberg Phoenix 2/18	536.45	3	2018	JRNL00194255	03/31/18	Regulatory	Allowable
CCMIDWST	072	6901	60000470	Acr Sandberg Phoenix 2/18	(536.45)	4	2018	JRNL00194378	04/30/18	Regulatory	Allowable
CCMIDWST	072	6901	60000470	Acr Sandberg Phoenix 2/18	536.45	4	2018	JRNL00195146	04/30/18	Regulatory	Allowable
CCMIDWST	072	6901	60000470	Acr Sandberg Phoenix 2/18	(536.45)	5	2018	JRNL00195156	05/31/18	Regulatory	Allowable
CCMIDWST	072	6901	60000470	Acr Sandberg Phoenix 4/18	46.00	4	2018	JRNL00195147	04/30/18	Resident Matter	Allowable
CCMIDWST	072	6901	60000470	Acr Sandberg Phoenix 4/18	(46.00)	5	2018	JRNL00195157	05/31/18	Resident Matter	Allowable
CCMIDWST	072	6901	60000470	Acr Sandberg Phoenix 4/18	46.00	5	2018	JRNL00195848	05/31/18	Resident Matter	Allowable
CCMIDWST	072	6901	60000470	Acr Sandberg Phoenix 4/18	(46.00)	6	2018	JRNL00196038	06/30/18	Resident Matter	Allowable
CCMIDWST	072	6901	60000470	Acr Sandberg Phoenix 5/18	345.05	5	2018	JRNL00195875	05/31/18	Resident Matter	Allowable
CCMIDWST	072	6901	60000470	Acr Sandberg Phoenix 5/18	(345.05)	6	2018	JRNL00196039	06/30/18	Resident Matter	Allowable
CCMIDWST	072	6901	60000470	Acr Sandberg Phoenix 5/18	345.05	6	2018	JRNL00196704	06/30/18	Resident Matter	Allowable
CCMIDWST	072	6901	60000470	Acr Sandberg Phoenix 5/18	(345.05)	7	2018	JRNL00196900	07/31/18	Resident Matter	Allowable
CCMIDWST	072	6901	60000470	Acr Sandberg Phoenix 9/18	616.55	9	2018	JRNL00199291	09/30/18	Collection	NonAllowable
CCMIDWST	072	6901	60000470	Acr Sandberg Phoenix 9/18	(616.55)	10	2018	JRNL00199449	10/31/18	Collection	NonAllowable
CCMIDWST	072	6901	60000470	SANDBERG,PHOENIX & VON GONTARD - 099	27.50	2	2018	JRNL00193165	02/28/18	Collection	NonAllowable
CCMIDWST	072	6901	60000470	SANDBERG,PHOENIX & VON GONTARD - 099	536.45	5	2018	JRNL00195480	05/24/18	Regulatory	Allowable
CCMIDWST	072	6901	60000470	SANDBERG,PHOENIX & VON GONTARD - 099	46.00	6	2018	JRNL00196400	06/25/18	Resident Matter	Allowable
CCMIDWST	072	6901	60000470	SANDBERG,PHOENIX & VON GONTARD - 099	64.40	6	2018	JRNL00196448	06/28/18	Collection	NonAllowable
CCMIDWST	072	6901	60000470	SANDBERG,PHOENIX & VON GONTARD - 099	345.05	7	2018	JRNL00197241	07/24/18	Resident Matter	Allowable
CCMIDWST	072	6901	60000470	SANDBERG,PHOENIX & VON GONTARD - 099	25.55	9	2018	JRNL00199123	09/30/18	Collection	NonAllowable
CCMIDWST	072	6901	60000470	SANDBERG,PHOENIX & VON GONTARD - 099	616.55	10	2018	JRNL00199907	10/31/18	Collection	NonAllowable
CCMIDWST	072	6901	60000470	SANDBERG,PHOENIX & VON GONTARD - 099	115.00	10	2018	JRNL00199907	10/31/18	Guardianship	Allowable
CCMIDWST	072	6901	60000470	SANDBERG,PHOENIX & VON GONTARD - 099	656.40	10	2018	JRNL00199909	10/31/18	Regulatory	Allowable
CCMIDWST	072	6901	60000470	SANDBERG,PHOENIX & VON GONTARD - 099	1,096.60	11	2018	JRNL00200484	11/30/18	Regulatory	Allowable
					\$ 3,762.19						

Facility Name & ID Number Jacksonville Skl Nur & Rehab

0051433

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? Yes
If YES, give association name and amount. AHCA,IHCA \$4,082
- (3) Did the nursing home make political contributions or payments to a political 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. \$ 27,533 Line 10-02
- (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 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. \$ 194,224
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. \$ Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 - c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 1
 - d. Have vehicle usage logs been maintained? Yes
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
 - g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees