

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

I. IDPH License ID Number: <u>0050310</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																	
Facility Name: <u>Hillside Rehab & Care Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/16</u> to <u>12/31/16</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																																																	
Address: <u>1308 Game Farm Road</u> <u>Yorkville</u> <u>60560</u>		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																																	
County: <u>Kendall</u>																																																			
Telephone Number: <u>(630) 553-5811</u> Fax # <u>(630) 553-2740</u>																																																			
HFS ID Number: _____																																																			
Date of Initial License for Current Owners: <u>01/15/09</u>																																																			
Type of Ownership:																																																			
<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>☐</td><td>IRS Exemption Code _____</td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☒</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></td><td></td></tr></table>		☐	VOLUNTARY, NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	☐	IRS Exemption Code _____	☐	Corporation	☐	Other _____			☒	"Sub-S" Corp.					☐	Limited Liability Co.					☐	Trust					☐	Other _____				
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		☐	Trust																																																
		☐	Other _____																																																
In the event there are further questions about this report, please contact:																																																			
Name: <u>Cindy A. Tefteller</u>																																																			
Telephone Number: <u>(618) 465-7717</u>																																																			
Email Address: _____																																																			
		Officer or Administrator of Provider																																																	
		(Signed) _____ (Date) _____																																																	
		(Type or Print Name) <u>Jason Mills</u>																																																	
		(Title) <u>Director of Corporate Accounting and IT Systems</u>																																																	
		(Signed) <u>See Accountant's Preparation Report</u> (Date) _____																																																	
		Paid Preparer																																																	
		(Print Name and Title) <u>Cindy A. Tefteller</u> <u>Partner</u>																																																	
		(Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C</u> <u>233 E Center Drive, Alton, IL 62002</u>																																																	
		(Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u>																																																	
		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																																																	
SEE ACCOUNTANTS' PREPARATION REPORT																																																			

Facility Name & ID Number Hillside Rehab & Care Center

0050310 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 <u>N/A</u>					
	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>79</u>	Skilled (SNF)	<u>79</u>	<u>28,914</u>	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	<u>79</u>	TOTALS	<u>79</u>	<u>28,914</u>	7

B. Census-For the entire report period.						
	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>9,516</u>	<u>6,087</u>	<u>4,412</u>	<u>20,015</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,516</u>	<u>6,087</u>	<u>4,412</u>	<u>20,015</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.22%

SEE ACCOUNTANTS' PREPARATION REPORT

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)
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 01/15/09

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 01/15/09 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 79 and days of care provided 2,223

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 Hillside Rehab & Care Center # 0050310 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	180,035	8,115	10,141	198,291		198,291		198,291			1
2	Food Purchase		102,734		102,734		102,734	(155)	102,579			2
3	Housekeeping	119,467	84,441	1,946	205,854		205,854		205,854			3
4	Laundry		38,737	150,188	188,925		188,925		188,925			4
5	Heat and Other Utilities			76,757	76,757		76,757	(12,786)	63,971			5
6	Maintenance	19,999	14,559	49,036	83,594		83,594		83,594			6
7	Other (specify):*											7
8	TOTAL General Services	319,501	248,586	288,068	856,155		856,155	(12,941)	843,214			8
	B. Health Care and Programs											
9	Medical Director			8,400	8,400		8,400		8,400			9
10	Nursing and Medical Records	1,176,255	111,202	61,824	1,349,281		1,349,281	9,243	1,358,524			10
10a	Therapy		458		458		458	767	1,225			10a
11	Activities	46,886	2,618	1,763	51,267		51,267		51,267			11
12	Social Services	45,602	36	544	46,182		46,182		46,182			12
13	CNA Training											13
14	Program Transportation			2,781	2,781		2,781		2,781			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,268,743	114,314	75,312	1,458,369		1,458,369	10,010	1,468,379			16
	C. General Administration											
17	Administrative	84,746		210,000	294,746		294,746	(190,247)	104,499			17
18	Directors Fees											18
19	Professional Services			17,789	17,789		17,789	2,988	20,777			19
20	Dues, Fees, Subscriptions & Promotions			80,860	80,860		80,860	(50,272)	30,588			20
21	Clerical & General Office Expenses	73,752	23,310	86,989	184,051		184,051	103,117	287,168			21
22	Employee Benefits & Payroll Taxes			266,639	266,639		266,639	16,301	282,940			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,360	5,360		5,360	3,750	9,110			24
25	Other Admin. Staff Transportation			6,061	6,061		6,061	4,833	10,894			25
26	Insurance-Prop.Liab.Malpractice			66,229	66,229		66,229	768	66,997			26
27	Other (specify):*											27
28	TOTAL General Administration	158,498	23,310	739,927	921,735		921,735	(108,762)	812,973			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,746,742	386,210	1,103,307	3,236,259		3,236,259	(111,693)	3,124,566			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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			30,527	30,527		30,527	5,583	36,110			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							8	8			32
33	Real Estate Taxes			78,693	78,693		78,693	14	78,707			33
34	Rent-Facility & Grounds			401,506	401,506		401,506	7,638	409,144			34
35	Rent-Equipment & Vehicles			62,878	62,878		62,878	(28,926)	33,952			35
36	Other (specify):*											36
37	TOTAL Ownership			573,604	573,604		573,604	(15,683)	557,921			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		147,839	336,380	484,219		484,219	(1,215)	483,004			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			130,575	130,575		130,575		130,575			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		147,839	466,955	614,794		614,794	(1,215)	613,579			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,746,742	534,049	2,143,866	4,424,657		4,424,657	(128,591)	4,296,066			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(12,925)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(155)	2		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	(425)	20		17
18	Fines and Penalties				18
19	Entertainment	(2,988)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(160)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(35,468)	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	(15,809)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (67,930)		\$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(60,661)	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (60,661)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (128,591)		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Eliminate Gifts & Flowers	\$ (10,415)	20	1
2	Eliminate Lobbying & PAC Dues	(2,060)	20	2
3	Offset Medical Record Income	(982)	10	3
4	Eliminate IDPH Fees Disallowed	(2,352)	20	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				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	(15,809)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hillside Rehab & Care Center # 0050310 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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(155)	0	0	0	0	0	0	0	0	0	0	(155)	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	(12,925)	139	0	0	0	0	0	0	0	0	0	(12,786)	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	(13,080)	139	0	0	0	0	0	0	0	0	0	(12,941)	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	(982)	10,225	0	0	0	0	0	0	0	0	0	9,243	10
10a	Therapy	0	0	767	0	0	0	0	0	0	0	0	767	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(982)	10,225	767	0	0	0	0	0	0	0	0	10,010	16
	C. General Administration													
17	Administrative	0	(190,449)	202	0	0	0	0	0	0	0	0	(190,247)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(160)	3,148	0	0	0	0	0	0	0	0	0	2,988	19
20	Fees, Subscriptions & Promotions	(50,720)	448	0	0	0	0	0	0	0	0	0	(50,272)	20
21	Clerical & General Office Expenses	(2,988)	106,041	64	0	0	0	0	0	0	0	0	103,117	21
22	Employee Benefits & Payroll Taxes	0	16,172	129	0	0	0	0	0	0	0	0	16,301	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	3,749	1	0	0	0	0	0	0	0	0	3,750	24
25	Other Admin. Staff Transportation	0	4,812	21	0	0	0	0	0	0	0	0	4,833	25
26	Insurance-Prop.Liab.Malpractice	0	768	0	0	0	0	0	0	0	0	0	768	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(53,868)	(55,311)	417	0	0	0	0	0	0	0	0	(108,762)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(67,930)	(44,947)	1,184	0	0	0	0	0	0	0	0	(111,693)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Hillside Rehab & Care Center # 0050310 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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	1,296	4,287	0	0	0	0	0	0	0	0	5,583	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	8	0	0	0	0	0	0	0	0	8	32
33	Real Estate Taxes	0	14	0	0	0	0	0	0	0	0	0	14	33
34	Rent-Facility & Grounds	0	5,992	1,646	0	0	0	0	0	0	0	0	7,638	34
35	Rent-Equipment & Vehicles	0	0	(28,926)	0	0	0	0	0	0	0	0	(28,926)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	7,302	(22,985)	0	0	0	0	0	0	0	0	(15,683)	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	(1,215)	0	0	0	0	0	0	0	0	(1,215)	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	(1,215)	0	0	0	0	0	0	0	0	(1,215)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(67,930)	(37,645)	(23,016)	0	0	0	0	0	0	0	0	(128,591)	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
Stephen P. Miller	100	Helia Healthcare of Benton	Benton, IL	Bridgemark Healthcare	St. Louis, MO	Management Co.
		Helia Healthcare of Champaign	Champaign, IL	Helia Healthcare Services	Benton, IL	Laundry, Maint.
		Helia Healthcare of Energy	Energy, IL	Bridgemark Employer Serv.	St. Louis, MO	Human Resources
		Helia Healthcare of Olney	Olney, IL	Bridgemark Medical Serv.	St. Louis, MO	Medical Supplies
		Helia Healthare of Belleville	Belleville, IL	NW Rehab, LLC	St. Louis, MO	Therapy
		Frankfort Healthcare & Rehab Center	West Frankfort, IL	Mid-South Health Clinic	Poplar Bluff, MO	Clinic
		Helia Southbelt Healthcare	Belleville, IL			

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	5	Utilities	\$	Bridgemark Healthcare, LLC	100.00%	\$ 139	\$ 139	1
2	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	10,225	10,225	2
3	V	17	Management Fees	210,000	Bridgemark Healthcare, LLC	100.00%	19,551	(190,449)	3
4	V	19	Professional Services		Bridgemark Healthcare, LLC	100.00%	3,148	3,148	4
5	V	20	Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	448	448	5
6	V	21	Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	106,041	106,041	6
7	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	16,172	16,172	7
8	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	3,749	3,749	8
9	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	4,812	4,812	9
10	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	768	768	10
11	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	1,296	1,296	11
12	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	14	14	12
13	V	34	Rent		Bridgemark Healthcare, LLC	100.00%	5,992	5,992	13
14	Total			\$ 210,000			\$ 172,355	\$ * (37,645)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	21	Clerical & Office Supplies	\$	Bridgemark Medical Supply	100.00%	\$ 41	\$ 41	15
16	V	30	Depreciation		Bridgemark Medical Supply	100.00%	4,287	4,287	16
17	V	34	Building Rent		Bridgemark Medical Supply	100.00%	1,646	1,646	17
18	V	35	Equipment	29,520	Bridgemark Medical Supply	100.00%		(29,520)	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V	35	Equipment Rental		Bridgemark Healthcare, LLC	100.00%	594	594	24
25	V								25
26	V								26
27	V								27
28	V	10a	Therapy		NW Rehab, LLC	100.00%	767	767	28
29	V	17	Admin Salaries		NW Rehab, LLC	100.00%	202	202	29
30	V	21	Clerical & Office Supplies		NW Rehab, LLC	100.00%	23	23	30
31	V	22	Employee Benefits		NW Rehab, LLC	100.00%	129	129	31
32	V	24	Travel & Seminar		NW Rehab, LLC	100.00%	1	1	32
33	V	25	Other Admin Transportation		NW Rehab, LLC	100.00%	21	21	33
34	V	32	Interest		NW Rehab, LLC	100.00%	8	8	34
35	V	39	Ancillary Services	1,215	NW Rehab, LLC	100.00%		(1,215)	35
36	V								36
37	V								37
38	V								38
39	Total			\$ 30,735			\$ 7,719	\$ * (23,016)	39

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' PREPARATION REPORT

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			Helia Healthcare of Greenville	Greenville, IL				1
2			Helia Healthcare of Jerseyville	Jerseyville, IL				2
3			Helia Healthcare of Hillsboro	Hillsboro, IL				3
4			Helia Healthcare of Poplar Bluff	Poplar Bluff, MO				4
5			Helia Healthcare ofo Florissant	Florissant, MO				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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Hillside Rehab & Care Center # 0050310 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	Stephen P. Miller	Owner	Administrative	100.00	341,992	2.7	5.41	Distribution	\$ 19,551	17,8	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	\$ 19,551		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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number	Hillside Rehab & Care Center
--------------------------------------	---

0050310

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

Bridgemark Healthcare, LLC

Street Address

11970 Borman Drive, Suite 100

City / State / Zip Code

St. Louis, MO 63146

Phone Number

((314) 431-0511

Fax Number

((314) 754-9176

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6			
1	5	Utilities	Resident Days	370,125	13	\$ 2,569	\$ 20,015	\$ 139	1
2	10	Nursing & Medical Records	Resident Days	370,125	13	189,088	20,015	10,225	2
3	17	Owners Compensation	Resident Days	370,125	13	361,543	20,015	19,551	3
4	19	Professional Fees	Resident Days	370,125	13	58,207	20,015	3,148	4
5	20	Dues, Subscriptions	Resident Days	370,125	13	8,280	20,015	448	5
6	21	Salaries - Other	Resident Days	370,125	13	1,575,742	20,015	85,210	6
7	21	Clerical & Office Supplies	Resident Days	370,125	13	385,214	20,015	20,831	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	370,125	13	299,056	20,015	16,172	8
9	24	Seminars	Resident Days	370,125	13	69,325	20,015	3,749	9
10	25	Admin Staff Travel	Resident Days	370,125	13	88,978	20,015	4,812	10
11	26	Insurance	Resident Days	370,125	13	14,200	20,015	768	11
12	30	Depreciation	Resident Days	370,125	13	23,966	20,015	1,296	12
13	33	Real Estate Taxes	Resident Days	370,125	13	267	20,015	14	13
14	34	Building Rent	Resident Days	370,125	13	102,424	20,015	5,539	14
15	34	Rental - Storage Unit	Resident Days	370,125	13	8,376	20,015	453	15
16	35	Equipment Rental	Resident Days	370,125	13	10,984	20,015	594	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,198,219	\$ 1,764,830	\$ 172,949	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Hillside Rehab & Care Center # 0050310 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 Bridgemark Medical Supply
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	21	Clerical & Office Supplies	Revenue	121,165	7	\$ 168	\$	29,520	\$ 41	1
2	30	Depreciation	Revenue	121,165	7	17,596		29,520	4,287	2
3	34	Building Rent	Revenue	121,165	7	6,757		29,520	1,646	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					\$ 24,521	\$		\$ 5,974	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Hillside Rehab & Care Center # 0050310 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 NW Rehab, LLC
Street Address _____
City / State / Zip Code _____
Phone Number ()
Fax Number ()

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	6	Maintenance	Revenue	2,513,226	14	\$ 75	\$	1,215	\$	1
2	10	Nursing & Med	Revenue	2,513,226	14	407		1,215		2
3	10a	Therapy	Revenue	2,513,226	14	1,585,909	1,585,909	1,215	767	3
4	17	Admin Salaries	Revenue	2,513,226	14	417,103	417,103	1,215	202	4
5	20	Dues & Subscriptions	Revenue	2,513,226	14	864		1,215		5
6	21	Clerical & Office Supplies	Revenue	2,513,226	14	47,814		1,215	23	6
7	22	Employee Benefits	Revenue	2,513,226	14	267,498		1,215	129	7
8	24	Travel & Seminar	Revenue	2,513,226	14	2,935		1,215	1	8
9	25	Other Admin Trans	Revenue	2,513,226	14	42,896		1,215	21	9
10	32	Interest	Revenue	2,513,226	14	16,479		1,215	8	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					\$ 2,381,980	\$ 2,003,012		\$ 1,151	25

SEE ACCOUNTANTS' PREPARATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related													
	Long-Term													
1							\$		\$			\$	1	
2													2	
3													3	
4													4	
5													5	
	Working Capital													
6	MidCap Funding I, LLC		X	Line of Credit		10/22/09					Variable		6	
7	Related Party Allocations											8	7	
8													8	
9	TOTAL Facility Related						\$		\$			\$	8	9
	B. Non-Facility Related*													
10	Interest Income Offset												10	
11													11	
12													12	
13													13	
14	TOTAL Non-Facility Related						\$		\$			\$		14
15	TOTALS (line 9+line14)						\$		\$			\$	8	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.) SEE ACCOUNTANTS' PREPARATION REPORT

** 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 2015 report.			\$	53,104	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.)			\$	78,693	2
3. Under or (over) accrual (line 2 minus line 1).			\$	25,589	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	53,104	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.			\$	78,693	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	54,071	8	
		2012	51,866	9	
		2013	52,720	10	
		2014	58,954	11	
		2015	78,693	12	
78,693 Line 7, Real Estate tax Portion of Lease Payments				13	FROM R. E. TAX STATEMENT FOR 2015 \$ 13
14 Bridgemark Healthcare Allocation				14	PLUS APPEAL COST FROM LINE 5 \$ 14
78,707 Total Schedule V, Line 33				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.

SEE ACCOUNTANTS' PREPARATION REPORT

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Hillside Rehab & Care Center COUNTY Kendall

FACILITY IDPH LICENSE NUMBER 0050310

CONTACT PERSON REGARDING THIS REPORT Jason Mills

TELEPHONE (314) 317-2003 FAX #: (314) 754-9176

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) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 02-29-278-017	Lot 1 Unit 13 Countryside Sub	\$ 68,381.78	\$ 68,381.78
2. 02-29-278-008	See 29-37-7	\$ 6,930.10	\$ 6,930.10
3. 02-29-278-018	Lot 12 Unit 1 & Lot 16 Unit 2	\$ 3,380.70	\$ 3,380.70
4.	Countryside Sub	\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 78,692.58	\$ 78,692.58

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 providecopies of their original second installment tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,390

B. General Construction Type: ExteriorMasonryFrameBrickNumber of Stories1

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:

1		2		3		4	
Use		Square Feet		Year Acquired		Cost	
1	Section N/A					\$	1
2							2
3	TOTALS					\$	3

SEE ACCOUNTANTS' PREPARATION REPORT

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	Therapy Door			2009	1,630	109	15	109		824	9
10	Wallcovering, Shower Room Remodel, Nurses Station & Entryway			2009	15,951	1,063	15	1,063		7,709	10
11	Carpet			2009	3,509		5			3,509	11
12	Concrete			2009	3,500	233	15	233		1,653	12
13	Carpet			2009	3,389		5			3,389	13
14	Hallway Wing 1-paint, crown molding			2010	5,752	383	15	383		2,652	14
15	Oakwall Cabinets for Nurses Station			2010	1,163	78	15	78		530	15
16	Reception Are - Countertop, paint, oakwork, drywall			2010	5,127	342	15	342		2,278	16
17	Shower Room W1 Heater, Fire System Installation			2010	2,854	190	15	190		1,269	17
18	Shower Room W1 Heater, Fire System Installation			2010	2,854	190	15	190		1,269	18
19	4 Ton A/C Unit & Install			2010	3,155	316	10	316		2,077	19
20	Carpet			2010	3,473		5			3,473	20
21	Concrete Work (Drainage: W1, W2, Main)			2010	7,000	350	20	350		2,217	21
22	Hallway Wing 2-paint crown molding			2010	4,836	322	15	322		2,042	22
23	Facility Sinage - In building			2010	3,725	372	10	372		2,297	23
24	Dining Room - Paint, tile lights/blinds			2010	3,426	228	15	228		1,409	24
25	Beauty Show - Crown Molding, carpet tile, cabinet, light fixtures & paint			2011	2,648	177	15	177		1,060	25
26	Garage - Flooring, electrical work, drywall insulation & paint			2011	6,873	458	15	458		2,635	26
27	Fire Rated Doors & Fire Alarm Control Panel			2011	25,494	2,506	15	2,506		12,990	27
28	Water Heater			2012	1,365	137	10	137		660	28
29	Fans for ARCH Unit			2013	1,153	115	10	115		384	29
30	Blinds for ARCH unit			2013	1,820	364	5	364		1,213	30
31	Hillside Welcome Sign			2013	1,290	129	10	129		430	31
32	Cabinets for ARCH unit			2013	2,843	190	15	190		632	32
33	Drapes/paint for ARCH unit			2013	4,880	976	5	976		3,253	33
34	Flooring/Sink/Mirror for ARCH Unit			2013	6,011	601	10	601		2,003	34
35	Materials/Labor/Supplies for ARCH Unit			2013	32,364	2,158	15	2,158		7,192	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
SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Hillside Rehab & Care Center

0050310

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 Vanities/Shower/ Plumbing	2013	\$ 6,004	\$ 300	20	\$ 300	\$	\$ 925	37
38 Doors for ARCH Unit	2013	4,053	270	15	270		900	38
39 Air Conditioner	2013	2,010	201	10	201		720	39
40 Valances, paint, wall covering , esxit lights, new walls, floor								40
41 (cont.) finishes, window for new therapy room	2014	12,814	855	15	855		2,361	41
42 Cabinets for Therapy Room	2014	2,306	154	15	154		385	42
43 Flooring for new dining room	2014	1,261	84	15	84		203	43
44 Windows & wall coverings for Kitchen remodel	2014	2,295	153	15	153		344	44
45 New Windows	2014	1,765	176	10	176		367	45
46 2 A/C Units	2014	1,650	330	5	330		853	46
47 New Flooring for Wing 1 & Wing 2	2015	4,020	268	15	268		380	47
48 Water Heater	2016	5,800	435	10	435		435	48
49 Finishing touches on ARCH Unit & new therapy room - trim,								49
50 (cont.) painting, etc.	2014	29,250	1,950	15	1,950		1,950	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 Related Party Allocation - Bridgemark Healthcare LLC								63
64 New Office Build-Out	2011	7,344		20	389	389	2,121	64
65 Conference Room Chair Rail & Paint	2012	83		5	17	17	72	65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 238,740	\$ 17,163		\$ 17,569	\$ 406	\$ 83,065	70

SEE ACCOUNTANTS' PREPARATION REPORT

**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	\$150,686	\$12,700	\$17,855	\$5,155	3-15	\$65,891	71
72	Current Year Purchases	10,784	664	686	22	3-15	686	72
73	Fully Depreciated Assets	33,187					33,187	73
74								74
75	TOTALS	\$194,657	\$13,364	\$18,541	\$5,177		\$99,764	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				\$	\$	\$	\$		\$	76
77	Related Party Allocation - Bridgemark			719				4	719	77
78										78
79										79
80	TOTALS			\$719	\$	\$	\$		\$719	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$434,116	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$30,527	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$36,110	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$5,583	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$183,548	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	Section N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Section N/A	\$	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.

SEE ACCOUNTANTS' PREPARATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Elite Yorkville, LLC
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:		79		\$ 400,122			3
4	Additions							4
5	Related Party Allocations				7,638			5
6	Storage Rental				1,384			6
7	TOTAL		79		\$ 409,144			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: *

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: \$ 33,952 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	Section N/A		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1	2	3	4	5	6	7	8	
	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	10a,2	hrs	\$		\$	331		\$ 331	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,2	hrs				127		127	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescrpts				141,213		141,213	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Wound, Oxy, Enterals</u>	39,2					6,626		6,626	12
13	Other (specify): <u>X-Ray, Labs, Therapy</u>	39,3				335,165			335,165	13
14	TOTAL			\$		\$ 335,165	\$ 148,297		\$ 483,462	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 3,744	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 172,137)	874,023		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,486		7
8	Accounts Receivable (owners or related parties)	371,943		8
9	Other(specify): Deposits	58,150		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,312,346	\$	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	252,396		15
16	Equipment, at Historical Cost	89,081		16
17	Accumulated Depreciation (book methods)	(129,612)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	27,603		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 239,468	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,551,814	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 976,085	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	67,551		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,989		31
32	Accrued Real Estate Taxes(Sch.IX-B)	53,104		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Provider taxes	3,738		36
37	Due to other related parties	1,412		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,103,879	\$	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)	\$ 1,103,879	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 447,935	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,551,814	\$	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 659,158	1
2	Restatements (describe):		2
3	Prior Year Adjustment for Workers Comp Audit	59,581	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 718,739	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(270,804)	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)	\$ (270,804)	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)	\$ 447,935	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Hillside Rehab & Care Center

0050310

Report Period Beginning: 01/01/16

Ending: 12/31/16

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,117,691	1
2	Discounts and Allowances for all Levels	(58,800)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,058,891	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	90,732	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 90,732	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,277	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	142	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	1,448	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,867	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	26	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 26	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Medical Record Copies</u>	982	28
28a	<u>Miscellaneous</u>	355	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,337	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,153,853	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	856,155	31
32	Health Care	1,458,369	32
33	General Administration	921,735	33
	B. Capital Expense		
34	Ownership	573,604	34
	C. Ancillary Expense		
35	Special Cost Centers	484,219	35
36	Provider Participation Fee	130,575	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,424,657	40
41	Income before Income Taxes (line 30 minus line 40)**	(270,804)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (270,804)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,348,021	44
45	Private Pay - Net Inpatient Revenue	1,160,794	45
46	Medicare - Net Inpatient Revenue	1,060,137	46
47	Other-(specify) <u>Insurance</u>	324,813	47
48	Other-(specify) <u>Hospice</u>	165,126	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,058,891	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Filed Yet 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.

SEE ACCOUNTANTS' PREPARATION REPORT

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	2,992	2,992	\$ 121,525	\$ 40.62	1
2	Assistant Director of Nursing	40	40	1,200	30.00	2
3	Registered Nurses	15,858	16,767	492,610	29.38	3
4	Licensed Practical Nurses	3,960	4,045	118,316	29.25	4
5	CNAs & Orderlies	35,171	37,009	442,604	11.96	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,775	2,932	46,886	15.99	10
11	Social Service Workers	2,156	2,246	45,602	20.30	11
12	Dietician					12
13	Food Service Supervisor	1,988	2,210	55,076	24.92	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,908	10,261	124,959	12.18	15
16	Dishwashers					16
17	Maintenance Workers	888	945	19,999	21.16	17
18	Housekeepers	9,351	9,989	119,467	11.96	18
19	Laundry					19
20	Administrator	1,826	1,899	84,746	44.63	20
21	Assistant Administrator					21
22	Other Administrative	1,646	1,835	30,864	16.82	22
23	Office Manager	1,932	2,147	42,888	19.98	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	90,491	95,317	\$ 1,746,742 *	\$ 18.33	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 10,141	1,3	35
36	Medical Director		8,400	9,3	36
37	Medical Records Consultant		850	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		1,763	11,3	44
45	Social Service Consultant		544	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 21,698		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	101	\$ 6,127	10,3	50
51	Licensed Practical Nurses	21	1,016	10,3	51
52	Certified Nurse Assistants/Aides	1,180	29,511	10,3	52
53	TOTAL (lines 50 - 52)	1,302	\$ 36,654		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

STATE OF ILLINOIS

0050310

Report Period Beginning:

01/01/16

Ending:

12/31/16

Facility Name & ID Number

Hillside Rehab & Care Center

Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership %

Amount

Christopher Rayborn

Administrator

0

\$ 21,187

Cheryl Vittorio

Administrator

0

35,310

Lynn Blackburn

Administrator

0

28,249

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 84,746

B. Administrative - Other

Description

Amount

Bridgemark Healthcare LLC - Management Fees

\$ 210,000

TOTAL (agree to Schedule V, line 17, col. 3)

(Attach a copy of any management service agreement)

\$ 210,000

C. Professional Services

Vendor/Payee

Type

Amount

C.J. Schlosser & Company, LLC

Accounting Services

\$ 3,775

Paycome Payroll, LLC

Payroll Processing

11,066

Personnel Planner, Inc.

Unemployment Consulting

1,232

Allen A Lefkovitz & Assoc

Legal Fees - R.E. Tax Appeal

1,191

HK Payroll Service

Payroll Fees

365

Collections

Collections

160

TOTAL (agree to Schedule V, line 19, column 3)

(For legal fee disclosure, see page 39 of instructions)

\$ 17,789

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 76,754

Unemployment Compensation Insurance

48,800

FICA Taxes

127,744

Employee Health Insurance

10,204

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

401(k) Match

1,992

Employee Benefits

402

Other Employee Insurance

743

Related Party Allocation - Bridgemark

16,172

Related Party Allocation - NW Rehab

129

TOTAL (agree to Schedule V, line 22, col.8)

\$ 282,940

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

Description

Line #

Amount

Section N/A

\$

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$ 1,990

Advertising: Employee Recruitment

6,666

Health Care Worker Background Check

8,060

(Indicate # of checks performed)

Patient Background Checks

Dues & Subscriptions

4,103

Late Fees

6,703

Miscellaneous Licenses & Fees

2,618

Advertising

35,468

Related Pary Allocation - Bridgemark

448

Less: Public Relations Expense

()

Non-allowable advertising

(35,468)

Yellow page advertising

()

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 30,588

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

3,584

Seminar Expense

1,776

Related Party Allocation - Bridgemark

3,749

Related Party Allocation - NW Rehab

1

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$ 9,110

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

HFS 3745 (N-4-99)

IL478-2471

Facility Name & ID Number Hillside Rehab & Care Center	STATE OF ILLINOIS # 0050310	Report Period Beginning: 01/01/16	Ending: 12/31/16
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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? Yes
 If YES, give association name and amount. IHCA \$3,154

(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? 3-15 Yrs

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 23,011 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
 If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 130,575
 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. \$ None 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? N/A
 d. Have vehicle usage logs been maintained? N/A
 e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
 f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
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

SEE ACCOUNTANTS' PREPARATION REPORT

Hillside Rehab & Care Center
Attachment to Schedule XII B
Equipment Rentals
12/31/2016

Description		
16A	Nursing Equipment	27,767
16B	Copier Lease	4,523
16C	Dietary Equipment	1,068
16D	Related Party Allocation - Bridgemark Healthcare	594
		<u>33,952</u>