

		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: 0053447

Facility Name: Jerseyville Nsg & Rehab Ctr

Address: 1001 South State St Jerseyville 62052
Number City Zip Code

County: Jersey

Telephone Number: (618) 498-6496 Fax # (618) 498-7435

HFS ID Number:

Date of Initial License for Current Owners: 03/01/2015

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Cindy A. Tefteller Telephone Number: (618) 465-7717
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2016 to 12/31/2016 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed)
(Type or Print Name) Jason Mills
(Title) Director of Corporate Accounting and IT Systems

Paid
Preparer

(Signed) See Accountant's Preparation Report
(Print Name and Title) Cindy A. Tefteller Partner
(Firm Name & Address) C.J. Schlosser & Company, L.L.C.
233 E. Center Drive, Alton, IL 62002
(Telephone) (618) 465-7717 Fax # (618) 465-7710

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 Jerseyville Nsg & Rehab Ctr

0053447 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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>111</u>	Skilled (SNF)	<u>111</u>	<u>40,626</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>111</u>	TOTALS	<u>111</u>	<u>40,626</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>15,715</u>	<u>10,189</u>	<u>7,523</u>	<u>33,427</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>15,715</u>	<u>10,189</u>	<u>7,523</u>	<u>33,427</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.28%

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

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

Outpatient Therapy

F. Does the facility maintain a daily midnight census?

Yes

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

YES ☐ NO ☒

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

YES ☐ NO ☒

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

Date started 3/01/2015

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

YES ☒ Date 3/01/2015 NO ☐

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

YES ☒ NO ☐ If YES, enter number of beds certified 111 and days of care provided 6,173

Medicare Intermediary Novitas Solutions

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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Jerseyville Nsg & Rehab Ctr # 0053447 Report Period Beginning: 01/01/2016 Ending: 12/31/2016
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	232,742	24,214	7,673	264,629		264,629		264,629			1
2	Food Purchase		244,285		244,285		244,285	(369)	243,916			2
3	Housekeeping	134,322	32,135	1,161	167,618		167,618		167,618			3
4	Laundry	54,072	16,083		70,155		70,155		70,155			4
5	Heat and Other Utilities			142,416	142,416		142,416	(5,909)	136,507			5
6	Maintenance	63,896	14,774	55,735	134,405		134,405	22	134,427			6
7	Other (specify):*											7
8	TOTAL General Services	485,032	331,491	206,985	1,023,508		1,023,508	(6,256)	1,017,252			8
	B. Health Care and Programs											
9	Medical Director			18,012	18,012		18,012		18,012			9
10	Nursing and Medical Records	1,827,646	89,879	39,622	1,957,147		1,957,147	15,982	1,973,129			10
10a	Therapy		548		548		548		548			10a
11	Activities	41,206	1,237	3,293	45,736		45,736	(489)	45,247			11
12	Social Services	34,529		1,991	36,520		36,520		36,520			12
13	CNA Training											13
14	Program Transportation			16	16		16		16			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,903,381	91,664	62,934	2,057,979		2,057,979	15,493	2,073,472			16
	C. General Administration											
17	Administrative	103,990		355,000	458,990		458,990	(198,510)	260,480			17
18	Directors Fees											18
19	Professional Services			28,184	28,184		28,184	5,257	33,441			19
20	Dues, Fees, Subscriptions & Promotions			38,358	38,358		38,358	(20,403)	17,955			20
21	Clerical & General Office Expenses	91,664	22,739	108,917	223,320		223,320	191,129	414,449			21
22	Employee Benefits & Payroll Taxes			402,467	402,467		402,467	106,429	508,896			22
23	Inservice Training & Education											23
24	Travel and Seminar			541	541		541	7,132	7,673			24
25	Other Admin. Staff Transportation			6,256	6,256		6,256	20,772	27,028			25
26	Insurance-Prop.Liab.Malpractice			99,819	99,819		99,819	1,282	101,101			26
27	Other (specify):*											27
28	TOTAL General Administration	195,654	22,739	1,039,542	1,257,935		1,257,935	113,088	1,371,023			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,584,067	445,894	1,309,461	4,339,422		4,339,422	122,325	4,461,747			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			4,402	4,402		4,402	2,164	6,566			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,971	6,971		6,971	3,745	10,716			32
33	Real Estate Taxes			85,927	85,927		85,927	24	85,951			33
34	Rent-Facility & Grounds			673,850	673,850		673,850	10,006	683,856			34
35	Rent-Equipment & Vehicles			26,941	26,941		26,941	992	27,933			35
36	Other (specify):*											36
37	TOTAL Ownership			798,091	798,091		798,091	16,931	815,022			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		253,900	806,553	1,060,453		1,060,453	(275,322)	785,131			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			234,257	234,257		234,257		234,257			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		253,900	1,040,810	1,294,710		1,294,710	(275,322)	1,019,388			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,584,067	699,794	3,148,362	6,432,223		6,432,223	(136,066)	6,296,157			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	(489)	11		4
5	Telephone, TV & Radio in Resident Rooms	(6,141)	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	(1,148)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(369)	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				17
18	Fines and Penalties				18
19	Entertainment	(17)	21		19
20	Contributions	(150)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(15,304)	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	(7,320)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (30,938)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	(105,128)	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (105,128)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (136,066)		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	To Eliminate Gfts and Flowers	\$ (2,239)	20	1
2	To Eliminate Lobbying & PAC Dues	(3,865)	20	2
3	Offset Medical Records Income	(1,216)	10	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
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22				22
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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	(7,320)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Jerseyville Nsg & Rehab Ctr# 0053447

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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	(369)	0	0	0	0	0	0	0	0	0	0	(369)	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	(6,141)	232	0	0	0	0	0	0	0	0	0	(5,909)	5
6	Maintenance	0	0	22	0	0	0	0	0	0	0	0	22	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(6,510)	232	22	0	0	0	0	0	0	0	0	(6,256)	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	(1,216)	17,077	121	0	0	0	0	0	0	0	0	15,982	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(489)	0	0	0	0	0	0	0	0	0	0	(489)	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	(1,705)	17,077	121	0	0	0	0	0	0	0	0	15,493	16
	C. General Administration													
17	Administrative	0	(322,348)	123,838	0	0	0	0	0	0	0	0	(198,510)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	5,257	0	0	0	0	0	0	0	0	0	5,257	19
20	Fees, Subscriptions & Promotions	(21,408)	748	257	0	0	0	0	0	0	0	0	(20,403)	20
21	Clerical & General Office Expenses	(167)	177,100	14,196	0	0	0	0	0	0	0	0	191,129	21
22	Employee Benefits & Payroll Taxes	0	27,009	79,420	0	0	0	0	0	0	0	0	106,429	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	6,261	871	0	0	0	0	0	0	0	0	7,132	24
25	Other Admin. Staff Transportation	0	8,036	12,736	0	0	0	0	0	0	0	0	20,772	25
26	Insurance-Prop.Liab.Malpractice	0	1,282	0	0	0	0	0	0	0	0	0	1,282	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(21,575)	(96,655)	231,318	0	0	0	0	0	0	0	0	113,088	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(29,790)	(79,346)	231,461	0	0	0	0	0	0	0	0	122,325	29

Summary B

12/31/2016

[illegible]

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
<u>Stephen P. Miller</u>	<u>100</u>	<u>Helia Healthcare of Belleville</u>	<u>Belleville, IL</u>	<u>Bridgemark Healthcare</u>	<u>St. Louis, MO</u>	<u>Management co.</u>
		<u>Helia Healthcare of Benton</u>	<u>Benton, IL</u>	<u>Helia Healthcare Services</u>	<u>Benton, IL</u>	<u>Laundry, Maint.</u>
		<u>Franfort Healthcare & Rehab</u>	<u>West Frankfort, IL</u>	<u>Bridgemark Employer Srvs</u>	<u>St. Louis, MO</u>	<u>Human Resources</u>
		<u>Helia Healthare of Champaign</u>	<u>Champaign, IL</u>	<u>Bridgemeark Medical Supply</u>	<u>St. Louis, MO</u>	<u>Medical Supplies</u>
		<u>Helia Healthcare of Energy</u>	<u>Energy, IL</u>	<u>NW Rehab, LLC</u>	<u>St. Louis, MO</u>	<u>Therapy</u>
		<u>Helia Healthcare of Olney</u>	<u>Olney, IL</u>	<u>Mid-South Health Clinic</u>	<u>Poplar Bluff, MO</u>	<u>Clinic</u>
		<u>Helia Healthcare of Greenville</u>	<u>Greenville, IL</u>			

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	<u>Utilities</u>	\$	<u>Bridgemark Healthcare, LLC</u>	<u>100.00%</u>	<u>\$ 232</u>	<u>\$ 232</u>	1
2	V	10	<u>Nursing & Medical Records</u>		<u>Bridgemark Healthcare, LLC</u>	<u>100.00%</u>	<u>17,077</u>	<u>17,077</u>	2
3	V	17	<u>Management Fees</u>	<u>355,000</u>	<u>Bridgemark Healthcare, LLC</u>	<u>100.00%</u>	<u>32,652</u>	<u>(322,348)</u>	3
4	V	19	<u>Professinoal Services</u>		<u>Bridgemark Healthcare, LLC</u>	<u>100.00%</u>	<u>5,257</u>	<u>5,257</u>	4
5	V	20	<u>Dues, Subscriptions</u>		<u>Bridgemark Healthcare, LLC</u>	<u>100.00%</u>	<u>748</u>	<u>748</u>	5
6	V	21	<u>Clerical & General Office</u>		<u>Bridgemark Healthcare, LLC</u>	<u>100.00%</u>	<u>177,100</u>	<u>177,100</u>	6
7	V	22	<u>Employee Benefits & Payroll Taxes</u>		<u>Bridgemark Healthcare, LLC</u>	<u>100.00%</u>	<u>27,009</u>	<u>27,009</u>	7
8	V	24	<u>Travel& Seminar</u>		<u>Bridgemark Healthcare, LLC</u>	<u>100.00%</u>	<u>6,261</u>	<u>6,261</u>	8
9	V	25	<u>Admin Staff Transportation</u>		<u>Bridgemark Healthcare, LLC</u>	<u>100.00%</u>	<u>8,036</u>	<u>8,036</u>	9
10	V	26	<u>Insurance</u>		<u>Bridgemark Healthcare, LLC</u>	<u>100.00%</u>	<u>1,282</u>	<u>1,282</u>	10
11	V	30	<u>Depreciataion</u>		<u>Bridgemark Healthcare, LLC</u>	<u>100.00%</u>	<u>2,164</u>	<u>2,164</u>	11
12	V	33	<u>Real Estate Taxes</u>		<u>Bridgemark Healthcare, LLC</u>	<u>100.00%</u>	<u>24</u>	<u>24</u>	12
13	V	34	<u>Rent</u>		<u>Bridgemark Healthcare, LLC</u>	<u>100.00%</u>	<u>10,006</u>	<u>10,006</u>	13
14	Total			\$ 355,000			\$ 287,848	\$ * (67,152)	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.

☒ X

 YES

☐ NO

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

1		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	35	Equipment Rental	\$	Bridgemark Healthcare, LLC	100.00%	\$ 992	\$ 992	15
16	V								16
17	V								17
18	V	6	Maintenance		NW Rehab, LLC	100.00%	22	22	18
19	V	10	Nursing & Med		NW Rehab, LLC	100.00%	121	121	19
20	V	39	Ancillary Service Centers		NW Rehab, LLC	100.00%	470,858	470,858	20
21	V	17	Administration		NW Rehab, LLC	100.00%	123,838	123,838	21
22	V	20	Dues & Subscriptions		NW Rehab, LLC	100.00%	257	257	22
23	V	21	Clerical & Office		NW Rehab, LLC	100.00%	14,196	14,196	23
24	V	22	Employee Benefits		NW Rehab, LLC	100.00%	79,420	79,420	24
25	V	24	Travel & Seminar		NW Rehab, LLC	100.00%	871	871	25
26	V	25	Other Admin Transp		NW Rehab, LLC	100.00%	12,736	12,736	26
27	V	32	Interest		NW Rehab, LLC	100.00%	4,893	4,893	27
28	V	39	Ancillary Service Centers	746,180	NW Rehab, LLC	100.00%		(746,180)	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			\$ 746,180			\$ 708,204	\$ * (37,976)	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 Southbelt Healthcare	Belleville, IL				1
2			Hillside Rehab & Care Center	Yorkville, IL				2
3			Helia Healthcare of Hillsboro	Hillsboro, IL				3
4			Helia Healthcare of Florissant	Florissant, MO				4
5			Helia Helthcare of Poplar Bluff	Poplar Bluff, 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 Jerseyville Nsg & Rehab Ctr # 0053447 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	328,891	4.52	9.03	Distribution	\$ 32,652	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	\$ 32,652		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 Jerseyville Nsg & Rehab Ctr # 0053447 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

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	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	5	Utilities	Resident Days	370,125	13	\$ 2,569	\$	33,427	\$ 232	1
2	10	Nursing & Medical Records	Resident Days	370,125	13	189,088	189,088	33,427	17,077	2
3	17	Owners Compensation	Resident Days	370,125	13	361,543		33,427	32,652	3
4	19	Professional Fees	Resident Days	370,125	13	58,207		33,427	5,257	4
5	20	Dues, Subscriptions	Resident Days	370,125	13	8,280		33,427	748	5
6	21	Salaries - Other	Resident Days	370,125	13	1,575,742	1,575,742	33,427	142,310	6
7	21	Clerical & Office Supplies	Resident Days	370,125	13	385,214		33,427	34,790	7
8	22	Emp. Benefits & Payroll Taxes	Resident Days	370,125	13	299,056		33,427	27,009	8
9	24	Seminars	Resident Days	370,125	13	69,325		33,427	6,261	9
10	25	Admin Staff Travel	Resident Days	370,125	13	88,978		33,427	8,036	10
11	26	Insurance	Resident Days	370,125	13	14,200		33,427	1,282	11
12	30	Depreciation	Resident Days	370,125	13	23,966		33,427	2,164	12
13	33	Real Estate Taxes	Resident Days	370,125	13	267		33,427	24	13
14	34	Building Rent	Resident Days	370,125	13	102,424		33,427	9,250	14
15	34	Rental - Storage Unit	Resident Days	370,125	13	8,376		33,427	756	15
16	35	Equipment Rental	Resident Days	370,125	13	10,984		33,427	992	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		\$ 288,840	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Jerseyville Nsg & Rehab Ctr # 0053447 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

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 N W 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	\$	746,180	\$ 22	1
2	10	Nursing & Med	Revenue	2,513,226	14	407		746,180	121	2
3	39	Therapy	Revenue	2,513,226	14	1,585,909	1,585,909	746,180	470,858	3
4	17	Admin Salaries	Revenue	2,513,226	14	417,103	417,103	746,180	123,838	4
5	20	Dues & Subscriptions	Revenue	2,513,226	14	864		746,180	257	5
6	21	Salaries - Other	Revenue	2,513,226	14			746,180		6
7	21	Clerical & Office Supplies	Revenue	2,513,226	14	47,814		746,180	14,196	7
8	22	Employee Benefits	Revenue	2,513,226	14	267,498		746,180	79,420	8
9	24	Travel & Seminar	Revenue	2,513,226	14	2,935		746,180	871	9
10	25	Other Admin Transp	Revenue	2,513,226	14	42,896		746,180	12,736	10
11	32	Interest	Revenue	2,513,226	14	16,479		746,180	4,893	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		\$ 707,212	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	6,971	6
7	Related Party Allocation - NW Rehab										4,893	7
8												8
9	TOTAL Facility Related						\$				\$ 11,864	9
	B. Non-Facility Related*											
10	Interest Income Offset										(1,148)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$				\$ (1,148)	14
15	TOTALS (line 9+line14)						\$				\$ 10,716	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.)

B. Real Estate Taxes

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.

IL478-2471

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Jerseyville Nsg & Rehab Ctr COUNTY Jersey

FACILITY IDPH LICENSE NUMBER 0053447

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. 04-875-004-00	Outlots 59, 62, 63, & 64 S PT Outlot 6	\$ 81,210.88	\$ 81,210.88
2. 04-208-017-00	S 28 T8 R11 Unplatted Parcels	\$ 4,715.96	\$ 4,715.96
3.	S&W PT SE 1/4 NE 1/4 Less E PT	\$	\$
4.	Less .10 ACS for HWY	\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 85,926.84	\$ 85,926.84

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.

A. Square Feet: 40,823

B. General Construction Type: Exterior Brick and SidingFrame Steel & BrickNumber of Stories 1

C. Does the Operating Entity?

☐ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☒ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES☐ NO

If so, please complete the following:

1. Total Amount Incurred: N/A

2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A

4. Dates Incurred: N/A

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	Facility -Prior Owner	158,994	1994	\$ 71,664	1
2					2
3	TOTALS	158,994		\$ 71,664	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Jerseyville Nsg & Rehab Ctr

0053447

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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	101		1994		\$ 1,180,668	\$		\$		4
5	10			2010	2,040,612					5
6										6
7										7
8										8
	Improvement Type**									
9	Prior Owner Capital Costs:									9
10	Exterior Remolding			1994	10,000					10
11	Electrical			1994	10,694					11
12	Air Conditioners			1994	25,830					12
13	Interior Remodeling			1994	20,598					13
14	Hearia Shed			1994	3,267					14
15	Nurses Station			1994	6,055					15
16	Painting			1995	7,392					16
17	Electrical Work			1995	3,382					17
18	Call Lights			1995	1,564					18
19	Storage Building			1996	3,500					19
20	Boiler			1996	7,400					20
21	Roof Repairs			1996	3,619					21
22	Ceiling Tiles & End Caps			1996	3,506					22
23	Storage Building			1997	3,356					23
24	Alarm System			1997	1,750					24
25	Ceiling Tiles			1997	1,485					25
26	3 Windows & Sills & 1 Door Replaced			1997	4,108					26
27	Air Conditioners			1997	2,186					27
28	Concrete Patio & Sidewalk			1997	1,842					28
29	Roofing			1998	2,592					29
30	Shower Room Remodeling			1998	1,437					30
31	Air Conditioners			1998	13,420					31
32	Air Conditioners			1999	2,841					32
33	New Roof			1999	35,386					33
34	Air Conditioners			2000	2,118					34
35	Chair Rails			2000	6,267					35
36	Constr of 400 Wing - Design, Archetecture & Engineering			2001	65,216					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 Jerseyville Nsg & Rehab Ctr

0053447

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

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 Constr. Of 400 Wing - Contractor Costs	2001	\$ 874,589	\$		\$	\$	\$	37
38 Const. of 400 Wing - Drawing, Surety Bond & Misc	2001	11,223						38
39 Const. of 400 Wing - Interest & Mortgage Ins. Premium	2001	83,401						39
40 400 Wing - Nurse Call System	2001	10,104						40
41 400 Wing - Cable TV System Cabling	2001	1,962						41
42 400 Wing - Fire Alarm System	2001	13,326						42
43 400 Wing - Door Monitoring System	2001	2,640						43
44 400 Wing - TV Wall Mounts	2001	5,851						44
45 400 Wing - Signage	2001	1,161						45
46 400 Wing - Handrails & Wall Guards	2001	2,319						46
47 400 Wing - Chair Rail	2001	4,208						47
48 400 Wing - Door Guards	2001	607						48
49 400 Wing - Cubicle Tracks, Curtains, Window Treatments	2001	7,169						49
50 Fencing	2001	4,200						50
51 Storage Building	2001	3,268						51
52 Nurse Call System Upgrades	2001	3,700						52
53 Fire Alarm Syte Control Panel	2001	3,903						53
54 Replacement Signage	2001	3,656						54
55 Door Guards	2001	1,979						55
56 Overbed Lights	2001	1,625						56
57 Painting	2001	8,932						57
58 2P 50 AMP Disconnect	2001	955						58
59 Mini Blinds	2001	14,744						59
60 Asphalts Paving of Parking Lot	2001	14,193						60
61 Air Conditioners	2001	3,424						61
62 Overbed Lights	2002	3,055						62
63 Cubicle Curtains	2002	6,155						63
64 Air Conditioners	2002	1,398						64
65 Security Camera System	2002	1,010						65
66 Fire Doors	2002	1,543						66
67 Roofing - North Entrance	2002	1,680						67
68 Wall Guard & End Caps	2002	1,497						68
69 Door Canopy	2002	3,800						69
70 TOTAL (lines 4 thru 69)		\$ 4,575,368	\$		\$	\$	\$	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Jerseyville Nsg & Rehab Ctr

0053447

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

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		\$ 4,575,368	\$		\$	\$	\$	1
2	Landscaping	2002	1,729						2
3	Landscaping	2003	18,902						3
4	Air Conditioners	2003	5,551						4
5	Landscaping, Plants, Trees	2004	4,371						5
6	100 Amp Transfer Switch to Generator	2004	11,865						6
7	Smoke Detectors	2004	1,600						7
8	Extend Activities Wall/ Replace Doors	2004	2,002						8
9	Air Conditions	2004	1,814						9
10	Cove Base	2004	2,188						10
11	Hollow Metel Double Door	2004	8,520						11
12	New Wall/Flooring - Kitchen	2004	2,983						12
13	Cubicle Curtains	2005	289						13
14	Generator Control Panel	2005	3,689						14
15	Resident Room Doors	2005	19,393						15
16	Fire Doors	2005	4,955						16
17	Water Heater	2005	4,000						17
18	Replace Generator	2005	5,690						18
19	Air Conditioners	2005	1,753						19
20	Electircal Wiring	2005	4,862						20
21	Kitchen & Laundry Flooring	2005	2,556						21
22	4-Door Monitor System	2006	2,696						22
23	2 Door Awning - Side & Back Entrances	2006	1,671						23
24	Built-In Waterfall	2006	3,499						24
25	Drywall	2006	1,234						25
26	Wallpaper	2006	5,219						26
27	Lobby Remodeling	2006	17,774						27
28	4-Ton Heat Pump	2006	5,580						28
29	Glass Doors	2006	47,653						29
30	Air Conditioners	2006	9,474						30
31	Vinyl Flooring	2006	6,924						31
32	Kitchen Tyle	2006	4,411						32
33	Sprinkler System Improvements	2006	5,025						33
34	TOTAL (lines 1 thru 33)		\$ 4,795,240	\$		\$	\$	\$	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Jerseyville Nsg & Rehab Ctr

0053447

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12B, Carried Forward		\$ 4,795,240	\$		\$	\$	\$	1
2 Carpet	2006	2,775						2
3 Electrical Wiring	2006	15,869						3
4 Smoke Damper Motor	2006	1,793						4
5 Vinyl Fencing	2006	12,359						5
6 Coincrete Patio & Sidewalk	2006	10,744						6
7 Landscaping, Rock, Mulch	2006	4,325						7
8 Wallpaper	2007	12,135						8
9 Air Conditioners	2007	16,341						9
10 Flooring	2007	31,280						10
11 Alarm System	2007	4,732						11
12 Handrails	2007	11,039						12
13 Roof	2007	5,700						13
14 Satelite System	2007	16,581						14
15 Electrical For HV AV Unit	2007	3,964						15
16 Courtyard Landscaping	2007	3,800						16
17 Courtyard Pavillion Constructed	2007	9,870						17
18 Asphalt, Seal, Stripe Parking Lot	2007	13,500						18
19 Stainless Steel Backsplash	2007	2,523						19
20 Drywall	2007	3,790						20
21 Flooring	2008	23,598						21
22 Wallpaper	2008	31,055						22
23 Hot Water Heaters	2008	14,000						23
24 Network Cabling	2008	2,646						24
25 Front Porch Entrance	2008	63,826						25
26 Sprinkler System	2008	16,900						26
27 Electric Installation on Trailer	2008	3,236						27
28 Facility Signage	2008	3,212						28
29 Landscaping	2008	5,700						29
30 Flooring	2009	71,018						30
31 300 KW Cummins Generator - Whole Bldg	2009	104,540						31
32 Needlet Remodeling - Wallpaper & Paint	2009	12,345						32
33 Replace 2" Drain Line	2009	4,111						33
34 TOTAL (lines 1 thru 33)		\$ 5,334,547	\$		\$	\$	\$	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Jerseyville Nsg & Rehab Ctr

0053447

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

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 12C, Carried Forward		\$ 5,334,547	\$		\$	\$	\$	1
2	<u>Roofing</u>	2009	3,000						2
3	<u>Flooring - Existing Facility</u>	2010	21,980						3
4	<u>Pt Room Remodeling - Patching/Painting</u>	2010	2,925						4
5	<u>Roofing- Mansard Wall</u>	2010	2,222						5
6	<u>Replace 55 sprinkler heads</u>	2010	2,100						6
7	<u>2 AC/Heat Units</u>	2010	1,396						7
8	<u>Dr's Room Sink</u>	2010	1,356						8
9	<u>400's hall Facility Signage</u>	2010	1,041						9
10	<u>Wall Guards & Hand Rails</u>	2010	4,749						10
11	<u>2 New Entracne Signs & Installation</u>	2010	8,704						11
12	<u>Landscaping</u>	2010	21,337						12
13	<u>Retaining Wall</u>	2010	8,829						13
14	<u>Asphalt, Seal, Stripe 400S Wing Lots</u>	2010	44,132						14
15	<u>Bumper Guards & Hand Rails</u>	2011	2,392						15
16	<u>Flooring</u>	2011	5,077						16
17	<u>2 Nursing Stations</u>	2011	3,590						17
18	<u>Hair Salon Labor & Material</u>	2011	2,432						18
19	<u>Hair Salon Plumbing</u>	2011	1,264						19
20	<u>Hair Salon Cabinet Allowance</u>	2011	288						20
21	<u>Hair Salon Electrical</u>	2011	475						21
22	<u>Conference Room Labor & Material</u>	2011	4,231						22
23	<u>Conference Room Plumbing</u>	2011	2,200						23
24	<u>Conference Room Cabinet Allowance</u>	2011	500						24
25	<u>Conference Room Electrical</u>	2011	825						25
26	<u>2 Electric Heater & A/C Unit</u>	2011	1,396						26
27	<u>Comprssor for A/C Unit</u>	2011	5,747						27
28	<u>Flooring</u>	2012	3,031						28
29	<u>6" Addition to Sewer</u>	2012	2,353						29
30	<u>2 Electric Heaters & A/C Unit</u>	2012	1,585						30
31	<u>A/C Compressor</u>	2012	1,600						31
32	<u>Concrete Pad & Sidewalks</u>	2012	1,300						32
33	<u>Painting/Patching/Repairing - 400 Hall (20 rooms)</u>	2013	7,550						33
34	TOTAL (lines 1 thru 33)		\$ 5,506,154	\$		\$	\$	\$	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Jerseyville Nsg & Rehab Ctr

0053447

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12D, Carried Forward		\$ 5,506,154	\$		\$	\$	\$	1
2 3 A/C/Heat Units	2013	2,358						2
3 Oxygen Storage Facility	2013	1,124						3
4 Concrete Pad & Sidewalk	2013	2,250						4
5 Electric Door Closer	2014	690						5
6 Painting	2014	400						6
7 Ceiling Tile	2014	1,066						7
8 A/C Units	2014	3,241						8
9 Door Alarm System	2014	25,765						9
10 Flooring-Labor Only	2014	992						10
11 Landscaping	2014	2,215						11
12								12
13								13
14 Stage 1 Compressor replacement	2016	4,652	194	12	194		194	14
15								15
16								16
17								17
18								18
19								19
20								20
21 Related Party Allcation - Bridgemark:								21
22 New Office Build Out	2011	12,266		20	650	650	3,542	22
23 Conference Rm Chari Rail & Paint	2012	139		5	28	28	120	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)		\$ 5,563,312	\$ 194		\$ 872	\$ 678	\$ 3,856	34

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	\$23,946	\$3,121	\$4,570	\$1,449	3-15	\$9,106	71
72	Current Year Purchases	10,443	1,087	1,124	37	3-15	1,124	72
73	Fully Depreciated Assets	7,775					7,775	73
74								74
75	TOTALS	\$42,164	\$4,208	\$5,694	\$1,486		\$18,005	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			1,200				4	1,200	77
78										78
79										79
80	TOTALS			\$1,200	\$	\$	\$		\$1,200	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)	\$5,678,340	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$4,402	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$6,566	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$2,164	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$23,061	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:Aviv, LLC.
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

☒ YES

☐ NO
- If NO, see instructions.

		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:		111		\$ 671,968			3
4	Additions							4
5	Storage Rental				1,882			5
6	Related Party Allocation - Bridgemark				10,006			6
7	TOTAL		111		\$ 683,856			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: \$ 27,933Description: 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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,2	hrs				548		548	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				229,333		229,333	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Wound, Oxy, Enterals	39,2					24,567		24,567	12
13	Other (specify): X-Ray, Labs, Therapy	39,8				531,231			531,231	13
14	TOTAL			\$		\$ 531,231	\$ 254,448		\$ 785,679	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	\$ 8,457	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 159,177)	1,700,261		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	12,409		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Deposits	127,671		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,848,798	\$	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	4,652		15
16	Equipment, at Historical Cost	25,090		16
17	Accumulated Depreciation (book methods)	(5,457)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	67,690		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 91,975	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,940,773	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 258,058	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	163,947		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,152		31
32	Accrued Real Estate Taxes(Sch.IX-B)	78,927		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Assessment Tax	29,027		36
37	Due to Related Parties	478,910		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,021,021	\$	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)	\$ 1,021,021	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 919,752	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,940,773	\$	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 344,820	1
2	Restatements (describe):		2
3	Prior Year Adjustments after Cost Report Issued	(27,199)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 317,621	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	602,131	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)	\$ 602,131	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)	\$ 919,752	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Jerseyville Nsg & Rehab Ctr

0053447

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

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	\$ 7,026,015	1
2	Discounts and Allowances for all Levels	(117,300)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,908,715	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	121,776	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 121,776	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	489	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 489	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,148	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,148	26
	E. Other Revenue (specify).****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	1,010	28
28a	Medical Record Copies	1,216	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,226	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,034,354	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,023,508	31
32	Health Care	2,057,979	32
33	General Administration	1,257,935	33
	B. Capital Expense		
34	Ownership	798,091	34
	C. Ancillary Expense		
35	Special Cost Centers	1,060,453	35
36	Provider Participation Fee	234,257	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,432,223	40
41	Income before Income Taxes (line 30 minus line 40)**	602,131	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 602,131	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,299,686	44
45	Private Pay - Net Inpatient Revenue	1,439,431	45
46	Medicare - Net Inpatient Revenue	2,904,909	46
47	Other-(specify) Insurance	158,413	47
48	Other-(specify) Hospice	106,276	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,908,715	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	1,871	2,106	\$ 67,411	\$ 32.01	1
2	Assistant Director of Nursing	2,054	2,207	63,591	28.81	2
3	Registered Nurses	11,569	12,344	299,139	24.23	3
4	Licensed Practical Nurses	16,402	17,769	381,157	21.45	4
5	CNAs & Orderlies	77,892	84,356	973,877	11.54	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,914	3,977	41,206	10.36	10
11	Social Service Workers	2,357	2,706	34,529	12.76	11
12	Dietician					12
13	Food Service Supervisor	1,786	2,001	25,878	12.93	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,956	22,834	206,864	9.06	15
16	Dishwashers					16
17	Maintenance Workers	3,739	4,076	63,896	15.68	17
18	Housekeepers	12,673	13,704	134,322	9.80	18
19	Laundry	5,602	6,061	54,072	8.92	19
20	Administrator	1,980	2,170	103,990	47.92	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,173	3,506	54,910	15.66	23
24	Clerical	2,560	2,836	36,754	12.96	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,816	3,207	42,471	13.24	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	171,344	185,860	\$ 2,584,067 *	\$ 13.90	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		\$ 7,673	1,3	35
36	Medical Director		18,012	9,3	36
37	Medical Records Consultant		1,261	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		9,148	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		3,293	11,3	44
45	Social Service Consultant		1,991	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 41,378		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Suzanne Bellm-Boston	Administrator	0	\$ 103,990
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 103,990
B. Administrative - Other			
Description			Amount
Bridgemark Healthcare L.L.C. - Management Fees		\$	355,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 355,000
C. Professional Services			
Vendor/Payee	Type		Amount
Paycom Payroll, LLC	Payroll Processing	\$	15,057
Personnel Planners, Inc.	Unemployment Consulting		1,382
Resident Trust Account	Reimbursement		129
Ashman and Stein	Legal Fees		198
C.J. Schlosser & Company, LLC	Accounting Fees		3,775
Much Shelist	Legal Fees		7,643
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 28,184
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	108,611
Unemployment Compensation Insurance			66,483
FICA Taxes			192,147
Employee Health Insurance			28,532
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
401(k) Match			5,099
Employee Benefits			742
Other Employee Insurance			853
Related Party Allocation - Bridgemark			27,009
Related Party Allocation - NW Rehab			79,420
TOTAL (agree to Schedule V, line 22, col.8)			\$ 508,896
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			2,536
Health Care Worker Background Check (Indicate # of checks performed _____)			2,120
Patient Background Checks			
Dues & Subscriptions			5,837
Late Fees			3,900
Miscellaneous Licenses & Fees			567
Advertising			15,304
Related Party Allocations			1,005
Less: Public Relations Expense	(		)
Non-allowable advertising			(15,304)
Yellow page advertising	(		)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 17,955
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			298
Seminar Expense			243
Related Party Allocation - Bridgemark			6,261
Related Party Allocation - NW Rehab			871
Entertainment Expense	(		)
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	7,673

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT**

****See instructions.**

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?

If YES, give association name and amount. IHCA \$5,104

(3) Did the nursing home make political contributions or payments to a political action organization?

If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases?

What was the average life used for new equipment added during this period?

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?

If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement?

YESNO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YESNO

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.

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?

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?

(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?

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?

(16) Travel and Transportation

a. Are there costs included for out-of-state travel?

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

If YES, please indicate the amount of income earned from such a program during this reporting period.

c. What percent of all travel expense relates to transportation of nurses and patients?

d. Have vehicle usage logs been maintained?

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

g. Does the facility transport residents to and from day training?

Indicate the amount of income earned from providing such transportation during this reporting period.

(17) Has an audit been performed by an independent certified public accounting firm?

Firm Name:

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

(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.

Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' PREPARATION REPORT

HFS 3745 (N-4-99)

IL478-2471

Helia Healthcare of Jerseyville
Attachment to Schedule XII B
Equipment Rentals
12/31/2016

Description		
16A	Specialty Beds	6,835
16B	Copier Lease	7,579
16C	Dietary Equipment	958
16D	Respiratory Equipment	11,569
16E	Related Party Allocation - Bridgemark Healthcare	992
		<u>27,933</u>