

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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>0053454</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Montgomery Nursing Rehab Ctr</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2020</u> to <u>12/31/2020</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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>State Rt 127 Box 309</u> <u>Hillsboro</u> <u>62049</u>																									
Number City Zip Code																									
County: <u>Montgomery</u>																									
Telephone Number: <u>(217) 532-6126</u> Fax # <u>(217) 532-9465</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Jason Mills</u></td></tr><tr><td>(Title) <u>Chief Financial Officer</u></td></tr><tr><td>(Signed) <u>See Accountant's Preparation Report</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>Cindy A. Tefteller</u> <u>Partner</u></td></tr><tr><td>(Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C</u> <u>233 E. Center Drive, Alton, IL 62002</u></td></tr><tr><td>(Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Jason Mills</u>	(Title) <u>Chief Financial Officer</u>	(Signed) <u>See Accountant's Preparation Report</u>	Paid Preparer	(Date) _____	(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>												
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	(Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u>																								
Date of Initial License for Current Owners: <u>03/01/2015</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</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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IRS Exemption Code _____	☐ Corporation	☐ Other _____																							
	☐ "Sub-S" Corp.																								
	☒ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		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																							
Name: <u>Cindy A. Tefteller</u> Telephone Number: <u>(618) 465-7717</u>																									
Email Address: _____																									

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Montgomery Nursing Rehab Ctr

0053454 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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>110</u>	Skilled (SNF)	<u>110</u>	<u>40,260</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>110</u>	TOTALS	<u>110</u>	<u>40,260</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>17,752</u>	<u>11,160</u>	<u>3,789</u>	<u>32,701</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>17,752</u>	<u>11,160</u>	<u>3,789</u>	<u>32,701</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.22%

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

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

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

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 03/01/2015

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

YES

☒

Date 03/01/2015

NO

☐

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

YES

☒

NO

☐

If YES, enter number

of beds certified

110

and days of care provided

3,040

Medicare Intermediary Novitas Solutions

IV. ACCOUNTING BASIS

ACCRUAL

☒

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

☒

NO

☐

Tax Year: 12/31/2020

Fiscal Year: 12/31/2020

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Montgomery Nursing Rehab Ctr # 0053454 Report Period Beginning: 01/01/2020 Ending: 12/31/2020
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	263,324	14,374	7,289	284,987		284,987		284,987			1
2	Food Purchase		201,569		201,569		201,569	(341)	201,228			2
3	Housekeeping	129,536	43,403	300	173,239		173,239		173,239			3
4	Laundry	68,201	22,627		90,828		90,828		90,828			4
5	Heat and Other Utilities			100,800	100,800		100,800	(6,587)	94,213			5
6	Maintenance	98,823	37,418	59,882	196,123		196,123		196,123			6
7	Other (specify):*											7
8	TOTAL General Services	559,884	319,391	168,271	1,047,546		1,047,546	(6,928)	1,040,618			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	2,188,134	244,828	68,929	2,501,891		2,501,891	46,795	2,548,686			10
10a	Therapy		312		312		312		312			10a
11	Activities	68,998	16,693	3,167	88,858		88,858		88,858			11
12	Social Services	59,031		556	59,587		59,587		59,587			12
13	CNA Training					983	983		983			13
14	Program Transportation			10,868	10,868		10,868		10,868			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,316,163	261,833	95,520	2,673,516	983	2,674,499	46,795	2,721,294			16
	C. General Administration											
17	Administrative	200,728		324,600	525,328		525,328	(291,802)	233,526			17
18	Directors Fees											18
19	Professional Services			35,566	35,566		35,566	10,649	46,215			19
20	Dues, Fees, Subscriptions & Promotions			52,798	52,798		52,798	(33,926)	18,872			20
21	Clerical & General Office Expenses	29,689	16,530	164,421	210,640		210,640	162,943	373,583			21
22	Employee Benefits & Payroll Taxes			367,299	367,299		367,299	19,044	386,343			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,888	1,888	(983)	905	2,872	3,777			24
25	Other Admin. Staff Transportation			13,281	13,281		13,281	4,099	17,380			25
26	Insurance-Prop.Liab.Malpractice			39,717	39,717		39,717	27,613	67,330			26
27	Other (specify):*											27
28	TOTAL General Administration	230,417	16,530	999,570	1,246,517	(983)	1,245,534	(98,508)	1,147,026			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,106,464	597,754	1,263,361	4,967,579		4,967,579	(58,641)	4,908,938			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 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			16,454	16,454		16,454	4,661	21,115			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,426	9,426		9,426	(181)	9,245			32
33	Real Estate Taxes			43,200	43,200		43,200	51	43,251			33
34	Rent-Facility & Grounds			716,070	716,070		716,070	8,621	724,691			34
35	Rent-Equipment & Vehicles			34,219	34,219		34,219	1,281	35,500			35
36	Other (specify):*											36
37	TOTAL Ownership			819,369	819,369		819,369	14,433	833,802			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		115,903	522,378	638,281		638,281	108,591	746,872			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			245,864	245,864		245,864		245,864			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		115,903	768,242	884,145		884,145	108,591	992,736			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,106,464	713,657	2,850,972	6,671,093		6,671,093	64,383	6,735,476			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	(7,237)	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	(181)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(341)	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	(280)	20		17
18	Fines and Penalties				18
19	Entertainment	(6,219)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(22,811)	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	(12,571)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (49,640)		\$	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)	114,023	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 114,023		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 64,383		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 Gifts and Flowers	\$ (9,867)	20	1
2	To Eliminate Lobbying & PAC Dues	(2,704)	20	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
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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	(12,571)		49

Facility Name & ID Number Montgomery Nursing Rehab Ctr# 0053454Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	100.00	Helia Healthcare of Belleville	Belleville, IL	Bridgemark Healthcar	St. Ann, MO	Management Co.
		Helia Healthcare of Benton	Benton, IL	Helia Healthcare Servi	Benton, IL	Laundry, Maint.
		Helia Healthcare of Florissant	Florissant, MO	Bridgemark Employer	St. Ann, MO	Human Resources
		Helia Healthcare of Energy	Energy, IL	NW Rehab LLC	St. Louis, MO	Therapy
		Helia Healthcare of Olney	Olney, IL	Palladian Management	O'Fallon, IL	Management Co.
		Frankfort Healthcare & Rehab	West Frankfort, IL	Palladian Mt. Vernon	Mt. Vernon, IL	Assisted Living
		Helia Southbelt Healthcare	Belleville, IL	Palladian Taylorville A	Taylorville, IL	Assisted Living

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	\$	Bridgemark Healthcare, LLC	100.00%	\$ 650	\$ 650	1
2	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	36,388	36,388	2
3	V	17	Management Fees	324,600	Bridgemark Healthcare, LLC	100.00%	32,798	(291,802)	3
4	V	19	Professional Services		Bridgemark Healthcare, LLC	100.00%	10,649	10,649	4
5	V	20	Dues, Subscription		Bridgemark Healthcare, LLC	100.00%	1,736	1,736	5
6	V	21	Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	169,162	169,162	6
7	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	19,044	19,044	7
8	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	2,872	2,872	8
9	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	4,099	4,099	9
10	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	27,613	27,613	10
11	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	4,661	4,661	11
12	V	33	Real Estate Tax		Bridgemark Healthcare, LLC	100.00%	51	51	12
13	V	34	Rent		Bridgemark Healthcare, LLC	100.00%	8,621	8,621	13
14	Total			\$ 324,600			\$ 318,344	\$ * (6,256)	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	35	Equipment Rental	\$	Bridgemark Healthcare, LLC	100.00%	\$ 1,281	\$ 1,281	15
16	V								16
17	V								17
18	V	10	CNA assistance during COVID	47,441	NW Rehab, LLC	100.00%	57,848	10,407	18
19	V	39	Therapy	495,053	NW Rehab, LLC	100.00%	603,644	108,591	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 542,494			\$ 662,773	\$ * 120,279	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Montgomery Nursing Rehab Ctr

0053454

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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			Hillside Rehab & Care Center	Yorkville, IL				1
2			Helia Healthcare of Jerseyville	Jerseyville, IL				2
3			Helia Healthcare of Poplar Bluff	Poplar Bluff, MO				3
4			Helia Healthcare of Effingham	Effingham, IL				4
5			Helia Healthcare of Salem	Salem, IL				5
6			Palladian Senior Care of Poplar Bluff, L.L.C	Poplar Bluff, MO				6
7			Helia Richaldrn Healthcare, LLC	Olney, IL				7
8			Helia Healthcare of Newton, LLC	Newton, IL				8
9			Palladian Aviston SNF, LLC	Aviston, IL				9
10			Palladian Mt. Vernon SNF, LLC	Mt. Vernon, IL				10
11			Palladian Taylorville SNF, LLC	Taylorville, IL				11
12								12
13								13
14								14
15								15
16								16
17								17
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SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Montgomery Nursing Rehab Ctr # 0053454 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	373,630	4.03	8.07	Distribution	\$ 32,798	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	\$ 32,798		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 Montgomery Nursing Rehab Ctr # 0053454 Report Period Beginning: 01/01/2020 Ending: 2/31/2020

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 500 NW Plaza Dr., Suite 712
City / State / Zip Code Saint Ann, MO 63074
Phone Number (314) 431-0511
Fax Number (314) 457-9176

	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	405,225	17	\$ 8,060	\$	32,701	\$ 650	1
2	10	Nursing & Medical Records	Resident Days	405,225	17	450,909	450,909	32,701	36,388	2
3	17	Owner's Compensation	Resident Days	405,225	17	406,428		32,701	32,798	3
4	19	Professional Fees	Resident Days	405,225	17	131,963		32,701	10,649	4
5	20	Dues, Subscriptions	Resident Days	405,225	17	21,510		32,701	1,736	5
6	21	Salaries - Other	Resident Days	405,225	17	1,662,655	1,662,655	32,701	134,174	6
7	21	Clerical & Office Supplies	Resident Days	405,225	17	433,562		32,701	34,988	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	405,225	17	235,995		32,701	19,044	8
9	24	Seminars	Resident Days	405,225	17	35,584		32,701	2,872	9
10	25	Admin Staff Travel	Resident Days	405,225	17	50,795		32,701	4,099	10
11	26	Insurance	Resident Days	405,225	17	342,172		32,701	27,613	11
12	30	Depreciation	Resident Days	405,225	17	57,762		32,701	4,661	12
13	33	Real Estate Taxes	Resident Days	405,225	17	629		32,701	51	13
14	34	Building Rent	Resident Days	405,225	17	97,672		32,701	7,882	14
15	34	Rental - Storage	Resident Days	405,225	17	9,163		32,701	739	15
16	35	Equipment Rental	Resident Days	405,225	17	15,876		32,701	1,281	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,960,735	\$ 2,113,564		\$ 319,625	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 IV Trust		X	Line of Credit		10/22/09					Variable	8,123	6	
7	Omnicare		X	Vendor Note							7.5000	303	7	
8	Medline		X	Vendor Note		11/15/19					8.0000	1,000	8	
9	TOTAL Facility Related						\$		\$			\$ 9,426	9	
	B. Non-Facility Related*													
10	Interest Income Offset											(181)	10	
11													11	
12													12	
13													13	
14	TOTAL Non-Facility Related						\$		\$			\$ (181)	14	
15	TOTALS (line 9+line14)							\$		\$			\$ 9,245	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

1. Real Estate Tax accrual used on 2019 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	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.)			\$ 43,200	2
3. Under or (over) accrual (line 2 minus line 1).			\$ 43,200	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	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.			\$ 43,200	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2015	54,589	8	
	2016	46,326	9	
	2017	46,243	10	
	2018	42,897	11	
	2019	44,265	12	
43,200 Line 7, Real Estate Tax portion of Lease Payments				
51 Bridgemark Healthcare Allocation				
43,251 Total Schedule V, Line 33				
		FOR BHF USE ONLY		
		13	FROM R. E. TAX STATEMENT FOR 2019 \$	13
		14	PLUS APPEAL COST FROM LINE 5 \$	14
		15	LESS REFUND FROM LINE 6 \$	15
		16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' PREPARATION REPORT

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Montgomery Nursing Rehab Ctr COUNTY Montgomery

FACILITY IDPH LICENSE NUMBER 0053454

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 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 2019.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>16-13-379-001</u>	<u>NE PT SE SW Land Corp Limit</u>	\$ <u>44,265.32</u>	\$ <u>44,265.32</u>
2. _____	<u>Taylor Springs 8-4-716 3/4 S13</u>	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>44,265.32</u></u>	\$ <u><u>44,265.32</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,192

B. General Construction Type: Exterior BrickFrame 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:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility - Prior Owner	348,480	1994	\$ 27,673	1
2					2
3	TOTALS	348,480		\$ 27,673	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			1994		\$ 962,086	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Prior Owner Costs:									9
10	Shed			1994	3,247					10
11	Air Conditioner			1994	76,140					11
12	Cabinets			1994	6,809					12
13	Doors			1994	2,337					13
14	Electrical			1994	4,601					14
15	Exterior Remodeling			1994	4,468					15
16	Interior Remodeling			1994	57,810					16
17	Nurse Call System			1994	1,960					17
18	Plumbing			1994	6,619					18
19	Windows/Gutters			1994	60,254					19
20	Siding			1994	15,818					20
21	Metal Doors & Frames			1996	953					21
22	Dining Room Chair Rail			1997	2,230					22
23	Fire Doors			1997	593					23
24	Interior Painting			1997	514					24
25	Sidewalk Replacement			1997	650					25
26	Beauty Shop Remodeling			1998	4,287					26
27	Shower Room Remodeling			1998	1,199					27
28	Beauty Shop Remodeling			1998	566					28
29	Shower Room Remodeling			1998	6,040					29
30	Shelving			1998	208					30
31	Wall Mounted Laundry Tab			1998	181					31
32	Air Conditioning Unit			2000	557					32
33	Fire Doors			2001	1,535					33
34	Air Conditioning Unit			2001	1,696					34
35	Air Conditioning Unit			2002	1,446					35
36	Wall Guard			2002	1,927					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 Montgomery Nursing Rehab Ctr# 0053454

Report Period Beginning:

01/01/2020 Ending: 12/31/2020**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Fire Doors	2002	\$ 1,042	\$		\$	\$	\$	37
38	AC/Heat Pumps	2002	1,580						38
39	Air Conditioning Unit	2003	3,110						39
40	11 Fire Doors	2003	5,950						40
41	Closet Door - Resident Rooms	2004	3,628						41
42	Wiring Outside Lighs	2004	1,145						42
43	Tile	2004	878						43
44	Commercial Water Heater	2004	7,664						44
45	Floor Tile	2004	1,186						45
46	66 Gallon Hot Water Heater	2004	931						46
47	Patio & Sidewalks	2004	14,316						47
48	Concrete Dumpster Pad/Fencing	2004	1,520						48
49	Range Hood	2005	832						49
50	Closet Door - Resident Rooms	2005	3,689						50
51	Outside Lighting Features	2005	2,025						51
52	Air Conditioning Unit	2005	7,610						52
53	Electrical Work	2005	5,528						53
54	Tile & Cove Base	2005	2,064						54
55	Heating/Cooling Unit	2005	558						55
56	Wallpaper	2005	811						56
57	Therapy Room Cabinets	2005	1,200						57
58	New Roof - 200 & 500 Wings	2005	74,745						58
59	Wall Guard	2006	570						59
60	6 Oak Doors	2006	3,469						60
61	Smoke Detectors	2006	683						61
62	Exhausted Fans for Kitchen	2006	1,034						62
63	New Roof - 300 Wing	2007	30,200						63
64	Shower & Wall Remodel	2007	5,510						64
65	Water Heaters	2006	1,695						65
66	Air Conditioning Unit	2006	3,414						66
67	Storage Shed	2006	1,583						67
68	Fire Doors	2006	4,939						68
69	Patio & Sidewalks	2006	9,566						69
70	TOTAL (lines 4 thru 69)		\$ 1,431,406	\$		\$	\$	\$	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Montgomery Nursing Rehab Ctr# 0053454

Report Period Beginning:

01/01/2020 Ending: 12/31/2020**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		\$ 1,431,406	\$		\$	\$	\$	1
2	<u>Exhaust Fan Replacement</u>	2007	3,862						2
3	<u>Interior Remodeling - Shower Rooms</u>	2007	20,896						3
4	<u>Water Heaters</u>	2007	10,972						4
5	<u>Doors - Metal</u>	2007	4,450						5
6	<u>Air Conditioning Units</u>	2007	3,512						6
7	<u>Flooring</u>	2007	10,399						7
8	<u>Landscaping - Sign Area</u>	2007	2,575						8
9	<u>Repaved Driveway</u>	2007	4,750						9
10	<u>Flooring</u>	2008	132,076						10
11	<u>Wallpapering</u>	2008	45,923						11
12	<u>Electrical Work</u>	2008	11,765						12
13	<u>5 A/C Units & Installation</u>	2008	8,021						13
14	<u>Facility Storage</u>	2008	8,602						14
15	<u>8 Oak Doors</u>	2008	4,659						15
16	<u>In Wall Fountain - Labor & Materials</u>	2008	5,321						16
17	<u>Handrails & Hardware</u>	2008	8,950						17
18	<u>Cabinets, Countertops & Sinks</u>	2008	28,200						18
19	<u>5 Shaped Cornices</u>	2008	3,034						19
20	<u>Cabinet Installation</u>	2008	3,320						20
21	<u>3 A/C Units</u>	2009	1,839						21
22	<u>Sinks/Faucets - Resident Room</u>	2009	2,985						22
23	<u>Generator</u>	2009	50,432						23
24	<u>Roof Replacement - 100 & 400 Halls</u>	2009	36,200						24
25	<u>10 Upholstered Cornices</u>	2009	5,255						25
26	<u>Wi-Fi Access Installation</u>	2009	1,892						26
27	<u>Ceiling Tiles - Therapy Room</u>	2009	676						27
28	<u>Plexiglass for Maint. Shed</u>	2009	758						28
29	<u>Closet Doors</u>	2009	548						29
30	<u>New Entry Door</u>	2010	3,000						30
31	<u>4 A/C/Heat Units</u>	2010	2,618						31
32	<u>New 400 Amp Breaker</u>	2010	1,787						32
33	<u>Flooring</u>	2010	5,340						33
34	TOTAL (lines 1 thru 33)		\$ 1,866,023	\$		\$	\$	\$	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Montgomery Nursing Rehab Ctr# 0053454

Report Period Beginning:

01/01/2020 Ending: 12/31/2020**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 12B, Carried Forward		\$ 1,866,023	\$		\$	\$	\$	1
2	<u>Insulate Duct Work</u>	2010	14,800						2
3	<u>Kitchen Flooring</u>	2011	4,520						3
4	<u>Breaker Panel & Installation</u>	2011	10,994						4
5	<u>Sprinkler System</u>	2011	117,500						5
6	<u>6 A/C/Heat Units</u>	2011	4,502						6
7	<u>Motion Sensor/Dectectors</u>	2011	1,094						7
8	<u>Water Heaters</u>	2011	1,145						8
9	<u>Sidewalks</u>	2011	3,850						9
10	<u>Vinyl Fence & Gate</u>	2011	5,325						10
11	<u>Asphalt/Seal/Stripe/Patch & Repair Parking Lot</u>	2011	28,870						11
12	<u>Drainage Downspouts Installation</u>	2011	2,880						12
13	<u>Windows - Remove and Replace</u>	2012	9,480						13
14	<u>Flooring - Shower Room</u>	2012	4,602						14
15	<u>Flooring - Lunch Room</u>	2012	1,783						15
16	<u>2 Electric Heater/AC Units</u>	2012	1,605						16
17	<u>Security Locks</u>	2012	7,870						17
18	<u>Light Fixtures - Weather Proof</u>	2012	4,471						18
19	<u>100 Gal. Hot Water Heater</u>	2012	8,042						19
20	<u>10 A/C/Heat Units</u>	2013	7,491						20
21	<u>New Breaker for Lighting</u>	2013	2,466						21
22	<u>Nurse Call Sytsem Upgrade</u>	2013	7,082						22
23	<u>Electrical Work - 2 New Circuits</u>	2013	1,615						23
24	<u>5 New Vinyl Doors</u>	2013	765						24
25	<u>Hot Water Heater (10 Gal.) & Missing Valve</u>	2013	2,239						25
26	<u>5 Ton 13 Seer Rooftop A/C Unit</u>	2013	6,071						26
27	<u>400 & 500 Half Light Fixtures</u>	2013	3,195						27
28	<u>Plumbing for Stool & Lavatory</u>	2013	2,457						28
29	<u>Lighting Receptacles, fixtures, and ballasts</u>	2014	5,418						29
30	<u>New Cabinets, handles, and locks</u>	2014	10,075						30
31	<u>Relief Valve on Sprinler System</u>	2014	1,565						31
32	<u>A/C Units</u>	2014	10,016						32
33	<u>Electrical Work</u>	2014	24,349						33
34	TOTAL (lines 1 thru 33)		\$ 2,184,160	\$		\$	\$	\$	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Montgomery Nursing Rehab Ctr

0053454

Report Period Beginning:

01/01/2020 Ending: 12/31/2020

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		\$ 2,184,160	\$		\$	\$	\$	1
2	23 Wood Doors	2014	2,781						2
3	Shower Room Walls - Demo, Frame, and Drywall	2014	2,267						3
4	Flooring for Kitchen and Dining Room	2014	6,450						4
5	Plumbing - New Mixing Valves and Thermostat	2014	3,422						5
6	Wallpaper for Dining Room	2014	2,165						6
7	Landscaping	2014	2,360						7
8									8
9	Current Owner Additions:								9
10	Heating/Cooling System	2015	6,799	907	5	907		6,800	10
11	Bathroom Remodel	2017	20,778	2,078	10	2,078		6,926	11
12	Shower Room Remodel	2017	4,353	435	10	435		1,487	12
13	Rehab Room Heat Pump - Ductless	2018	3,610	361	10	361		1,053	13
14	Tandus Venue Flooring - Dining Room & Front Entry	2019	6,190	619	10	619		825	14
15	80 & 100 Gallon Water Heaters	2020	12,453	934	10	934		934	15
16									16
17									17
18									18
19									19
20	Related Part Allocation - Bridgemark:								20
21	New Office Build Out	2011	10,960		20	580	580	5,486	21
22	Conference Rm Chair Rail & Paint	2012	124		5			124	22
23	AC Unit in Server Room	2018	850		20	43	43	106	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,269,722	\$ 5,334		\$ 5,957	\$ 623	\$ 23,741	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	\$ 75,221	\$ 9,144	\$ 12,643	\$ 3,499	3-15 Yrs	\$ 33,722	71
72	Current Year Purchases	8,881	226	765	539	3-15 Yrs	765	72
73	Fully Depreciated Assets	14,516					14,516	73
74								74
75	TOTALS	\$ 98,618	\$ 9,370	\$ 13,408	\$ 4,038		\$ 49,003	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	Van		2017	\$ 7,000	\$ 1,750	\$ 1,750		4	\$ 6,271
77									
78									
79									
80	TOTALS			\$ 7,000	\$ 1,750	\$ 1,750			\$ 6,271

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)			\$ 2,403,013	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 16,454	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 21,115	
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$ 4,661	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 79,015	

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	\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92	Section N/A	\$
93		
94		
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: OMG Hillsboro Property, 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:		110		\$ 713,940			3
4	Additions							4
5	Storage Rental				2,130			5
6	Related Party Allocation - Bridgemark				8,621			6
7	TOTAL		110		\$ 724,691			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 N/A .
N/A
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: \$ 35,500 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

Helia Healthcare of Hillsboro
Attachment to Schedule XII B
Equipment Rentals
12/31/2020

Description		
16A	Specialty Bed Rental	14,618
16B	Respiratory Equipment	8,816
16C	Copier Lease	9,618
16D	Related Party Allocation - Bridgemark Healthcare	1,281
16E	Dietary Equipment	1,167
		<u>35,500</u>

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		503		503
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		480		480
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 983	\$	\$ 983
10	SUM OF line 9, col. 1 and 2 (e)	\$ 983			

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				312		312	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				97,186		97,186	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Wound, Oxy, Enterals</u>	39, 2					18,716		18,716	12
13	Other (specify): <u>X-Ray, Labs, Therapy</u>	39, 3				630,969			630,969	13
14	TOTAL			\$		\$ 630,969	\$ 116,214		\$ 747,183	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	\$ 9,839	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (30,000))	231,947		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,074		7
8	Accounts Receivable (owners or related parties)	1,394,255		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,639,115	\$	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	54,184		15
16	Equipment, at Historical Cost	86,048		16
17	Accumulated Depreciation (book methods)	(61,605)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 78,627	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,717,742	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 222,157	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	175,073		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,708		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Assessment Tax	14,811		36
37	Deferred CARES Funds	300,000		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 719,749	\$	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)	\$ 719,749	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 997,993	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,717,742	\$	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,022,801	1
2	Restatements (describe):		2
3	Prior year adjustment after cost report issued	967	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,023,768	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(25,775)	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)	\$ (25,775)	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)	\$ 997,993	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Montgomery Nursing Rehab Ctr

0053454

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

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	\$ 6,220,240	1
2	Discounts and Allowances for all Levels	(340,642)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,879,598	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	279,589	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 279,589	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		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)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	181	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 181	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>CARES Funds</u>	469,417	28
28a	<u>Miscellaneous</u>	16,533	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 485,950	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,645,318	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,047,546	31
32	Health Care	2,673,516	32
33	General Administration	1,246,517	33
	B. Capital Expense		
34	Ownership	819,369	34
	C. Ancillary Expense		
35	Special Cost Centers	638,281	35
36	Provider Participation Fee	245,864	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,671,093	40
41	Income before Income Taxes (line 30 minus line 40)**	(25,775)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (25,775)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,402,258	44
45	Private Pay - Net Inpatient Revenue	1,748,570	45
46	Medicare - Net Inpatient Revenue	1,487,601	46
47	Other-(specify) <u>Insurance</u>	156,801	47
48	Other-(specify) <u>Hospice</u>	84,368	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,879,598	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	1,938	2,154	\$ 85,310	\$ 39.61	1
2	Assistant Director of Nursing	2,097	2,231	77,832	34.89	2
3	Registered Nurses	6,888	7,369	225,204	30.56	3
4	Licensed Practical Nurses	17,731	19,782	510,976	25.83	4
5	CNAs & Orderlies	76,295	82,638	1,240,322	15.01	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,300	4,812	68,998	14.34	10
11	Social Service Workers	1,802	2,057	59,031	28.70	11
12	Dietician					12
13	Food Service Supervisor	1,995	2,165	56,916	26.29	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,811	16,107	206,407	12.81	15
16	Dishwashers					16
17	Maintenance Workers	3,783	4,259	98,823	23.20	17
18	Housekeepers	10,352	11,332	129,536	11.43	18
19	Laundry	4,871	5,477	68,201	12.45	19
20	Administrator	4,103	4,607	200,728	43.57	20
21	Assistant Administrator					21
22	Other Administrative	1,937	2,145	29,689	13.84	22
23	Office Manager					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	3,227	3,245	48,491	14.94	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	156,130	170,380	\$ 3,106,464 *	\$ 18.23	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		\$ 7,289	1, 3	35
36	Medical Director		12,000	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		10,321	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		556	11, 3	44
45	Social Service Consultant		556	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 30,722		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Carla Vonder Haar	Administrator	0	\$ 119,682	Workers' Compensation Insurance		\$ 36,094	IDPH License Fee	\$	
Lesley Brown	Asst. Administrator	0	81,046	Unemployment Compensation Insurance		17,008	Advertising: Employee Recruitment	330	
				FICA Taxes		232,142	Health Care Worker Background Check	784	
				Employee Health Insurance		69,588	(Indicate # of checks performed _____)		
				Employee Meals			Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions	8,142	
				401k Match		9,061	IHCA Dues	5,744	
				Employee Benefits		3,406	Miscellaneous Licenses & Fees	2,136	
							Advertising	22,811	
TOTAL (agree to Schedule V, line 17, col. 1)				Related Party Allocation - Bridgemark		19,044	Related Party Allocations	1,736	
(List each licensed administrator separately.)			\$ 200,728				Less: Public Relations Expense	()	
B. Administrative - Other							Non-allowable advertising	(22,811)	
Description			Amount				Yellow page advertising	()	
Bridgemark Healthcare, LLC - Management Fees			\$ 324,600				TOTAL (agree to Sch. V, line 20, col. 8)		
							\$ 18,872		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 324,600	TOTAL (agree to Schedule V, line 22, col.8)			\$ 386,343		
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
C. Professional Services				Description			Description		
Vendor/Payee	Type		Amount	Line #		Amount		Amount	
Personnel Planners	Unemployment Consulting	\$	2,141	Section N/A		\$	Out-of-State Travel	\$	
C.J. Schlosser & Company, LLC	Accounting Services		4,000						
Nationwide Trust	401k Admin		978						
Hepler Broom Law Firm	Legal Fees		2,574				In-State Travel		
Pantegra	401k Admin		3,100						
Paycom	Payroll Processing		22,773						
							Seminar Expense	905	
							Related Party Allocation - Bridgemark	2,872	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)		
(For legal fee disclosure, see page 39 of instructions)			\$ 35,566				TOTAL	\$ 3,777	

*** 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? Yes
If YES, give association name and amount. IHCA Dues \$5,744

(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. \$ 30,420 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. \$ 245,864
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? None

(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 benefits 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? Yes
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 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

HELIA HEALTHCARE OF HILLSBORO
RECLASSIFICATIONS
MEDICAID COST REPORT
12/31/20

	<u>AMOUNT</u>	<u>LN #</u>
A		
TRAVEL AND SEMINAR	(983)	24
C.N.A. TRAINING	983	13
TO RECLASS C.N.A. TRAINING		