

Facility Name & ID Number Hillside Rehab & Care Center

0050310 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	79	Skilled (SNF)	79	28,835	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	79	TOTALS	79	28,835	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	7,359	6,005	4,631	17,995	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,359	6,005	4,631	17,995	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.41%

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

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

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

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

None

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

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

YES NO

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

YES NO

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

Date started 01/15/09

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

YES Date 01/15/09 NO

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

YES NO If YES, enter number of beds certified 79 and days of care provided 2,306

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/15 Fiscal Year: 12/31/15

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Hillside Rehab & Care Center

0050310

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	175,751	9,569	9,924	195,244		195,244		195,244		1
2	Food Purchase		115,120		115,120		115,120	(190)	114,930		2
3	Housekeeping	111,680	36,146	1,466	149,292		149,292		149,292		3
4	Laundry		24,579	172,409	196,988		196,988		196,988		4
5	Heat and Other Utilities			79,295	79,295		79,295	(19,806)	59,489		5
6	Maintenance	42,726	26,418	59,146	128,290		128,290		128,290		6
7	Other (specify):*										7
8	TOTAL General Services	330,157	211,832	322,240	864,229		864,229	(19,996)	844,233		8
	B. Health Care and Programs										
9	Medical Director			19,400	19,400		19,400		19,400		9
10	Nursing and Medical Records	1,049,637	98,024	22,816	1,170,477		1,170,477	9,385	1,179,862		10
10a	Therapy		292		292		292		292		10a
11	Activities	40,169	3,342	1,668	45,179		45,179		45,179		11
12	Social Services	31,055		567	31,622		31,622		31,622		12
13	CNA Training										13
14	Program Transportation			5,141	5,141		5,141		5,141		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,120,861	101,658	49,592	1,272,111		1,272,111	9,385	1,281,496		16
	C. General Administration										
17	Administrative	81,796		198,400	280,196		280,196	(182,154)	98,042		17
18	Directors Fees										18
19	Professional Services			17,905	17,905		17,905	3,911	21,816		19
20	Dues, Fees, Subscriptions & Promotions			81,860	81,860		81,860	(53,137)	28,723		20
21	Clerical & General Office Expenses	82,203	19,233	73,650	175,086		175,086	91,431	266,517		21
22	Employee Benefits & Payroll Taxes			286,949	286,949		286,949	18,780	305,729		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,475	4,475		4,475	3,604	8,079		24
25	Other Admin. Staff Transportation			4,406	4,406		4,406	5,316	9,722		25
26	Insurance-Prop.Liab.Malpractice			65,037	65,037		65,037	1,108	66,145		26
27	Other (specify):*										27
28	TOTAL General Administration	163,999	19,233	732,682	915,914		915,914	(111,141)	804,773		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,615,017	332,723	1,104,514	3,052,254		3,052,254	(121,752)	2,930,502		29

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

SEE ACCOUNTANTS' COMPILATION 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			28,912	28,912	28,912	6,711	35,623				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,778	2,778	2,778	(611)	2,167				32
33	Real Estate Taxes			55,931	55,931	55,931	14	55,945				33
34	Rent-Facility & Grounds			393,646	393,646	393,646	7,036	400,682				34
35	Rent-Equipment & Vehicles			48,528	48,528	48,528	(28,753)	19,775				35
36	Other (specify):* Loss on Disposal			3,844	3,844	3,844		3,844				36
37	TOTAL Ownership			533,639	533,639	533,639	(15,603)	518,036				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		157,664	377,025	534,689	534,689		534,689				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			131,886	131,886	131,886		131,886				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		157,664	508,911	666,575	666,575		666,575				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,615,017	490,387	2,147,064	4,252,468	4,252,468	(137,355)	4,115,113				45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hillside Rehab & Care Center

0050310

Report Period Beginning: 01/01/15

Ending: 12/31/15

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(19,842)	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	(611)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(190)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(425)	20		17
18	Fines and Penalties	(4,236)	21		18
19	Entertainment	(3,860)	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	(46,727)	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	(6,699)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (82,590)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(54,765)	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (54,765)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (137,355)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		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' COMPILATION REPORT

BHF USE ONLY					
48		49		50	
				51	
				52	

Hillside Rehab & Care Center

ID# 0050310

Report Period Beginning: 01/01/15

Ending: 12/31/15

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Eliminate Gifts & Flowers	\$ (4,979)	20	1
2	Eliminate Lobbying & PAC Dues	(1,620)	20	2
3	Offset Medical Record Income	(100)	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
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(6,699)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hillside Rehab & Care Center

0050310

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(190)	0	0	0	0	0	0	0	0	0	0	(190)	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	(19,842)	36	0	0	0	0	0	0	0	0	0	(19,806)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(20,032)	36	0	(19,996)	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	(100)	9,485	0	0	0	0	0	0	0	0	0	9,385	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(100)	9,485	0	9,385	16								
	C. General Administration													
17	Administrative	0	(182,154)	0	0	0	0	0	0	0	0	0	(182,154)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,911	0	0	0	0	0	0	0	0	0	3,911	19
20	Fees, Subscriptions & Promotions	(53,751)	614	0	0	0	0	0	0	0	0	0	(53,137)	20
21	Clerical & General Office Expenses	(8,096)	99,362	165	0	0	0	0	0	0	0	0	91,431	21
22	Employee Benefits & Payroll Taxes	0	18,780	0	0	0	0	0	0	0	0	0	18,780	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	3,604	0	0	0	0	0	0	0	0	0	3,604	24
25	Other Admin. Staff Transportation	0	5,316	0	0	0	0	0	0	0	0	0	5,316	25
26	Insurance-Prop.Liab.Malpractice	0	1,108	0	0	0	0	0	0	0	0	0	1,108	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(61,847)	(49,459)	165	0	(111,141)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(81,979)	(39,938)	165	0	(121,752)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Hillside Rehab & Care Center

0050310

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	1,686	5,025	0	0	0	0	0	0	0	0	6,711	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(611)	0	0	0	0	0	0	0	0	0	0	(611)	32
33	Real Estate Taxes	0	14	0	0	0	0	0	0	0	0	0	14	33
34	Rent-Facility & Grounds	0	5,516	1,520	0	0	0	0	0	0	0	0	7,036	34
35	Rent-Equipment & Vehicles	0	0	(28,753)	0	0	0	0	0	0	0	0	(28,753)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(611)	7,216	(22,208)	0	(15,603)	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(82,590)	(32,722)	(22,043)	0	(137,355)	45							

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Stephen P. Miller	100	Helia Healthcare of Benton	Benton, IL	Bridgemark Healthcare	St. Louis, MO	Management Co.
		Helia Healthcare of Champaign	Champaign, IL	Helia Healthcare Services	Benton, IL	Laundry, Maint.
		Helia Healthcare of Energy	Energy, IL	Bridgemark Employer Serv.	St. Louis, MO	Human Resources
		Helia Healthcare of Olney	Olney, IL	Bridgemark Medical Serv.	St. Louis, MO	Medical Supplies
		Helia Healthcare of Belleville	Belleville, IL	NW Rehab, LLC	St. Louis, MO	Therapy
		Frankfort Healthcare & Rehab Center	West Frankfort, IL	Mid-South Health Clinic	Poplar Bluff, MO	Clinic
		Helia Southbelt Healthcare	Belleville, IL			

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

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

1 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%	\$ 36	\$ 36	1
2	V	10 Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	9,485	9,485	2
3	V	17 Management Fees	198,400	Bridgemark Healthcare, LLC	100.00%	16,246	(182,154)	3
4	V	19 Professional Services		Bridgemark Healthcare, LLC	100.00%	3,911	3,911	4
5	V	20 Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	614	614	5
6	V	21 Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	99,362	99,362	6
7	V	22 Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	18,780	18,780	7
8	V	24 Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	3,604	3,604	8
9	V	25 Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	5,316	5,316	9
10	V	26 Insurance		Bridgemark Healthcare, LLC	100.00%	1,108	1,108	10
11	V	30 Depreciation		Bridgemark Healthcare, LLC	100.00%	1,686	1,686	11
12	V	33 Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	14	14	12
13	V	34 Rent		Bridgemark Healthcare, LLC	100.00%	5,516	5,516	13
14	Total		\$ 198,400			\$ 165,678	\$ * (32,722)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	21 Clerical & Office Supplies	\$	Bridgemark Medical Supply	100.00%	\$ 165	\$	165	15
16	V	30 Depreciation		Bridgemark Medical Supply	100.00%	5,025		5,025	16
17	V	34 Building Rent		Bridgemark Medical Supply	100.00%	1,520		1,520	17
18	V	35 Equipment Rental	29,200	Bridgemark Medical Supply	100.00%			(29,200)	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V	35 Equipment Rental		Bridgemark Healthcare, LLC	100.00%	447		447	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		\$ 29,200			\$ 7,157	\$ *	(22,043)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Hillside Rehab & Care Center

0050310

Report Period Beginning:

01/01/15

Ending:

12/31/15

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Helia Healthcare of Greenville	Greenville, IL				1
2			Helia Healthcare of Jerseyville	Jerseyville, IL				2
3			Helia Healthcare of Hillsboro	Hillsboro, IL				3
4			Helia Healthcare of Poplar Bluff	Poplar Bluff, MO				4
5			Helia Healthcare of Florissant	Florissant, MO				5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hillside Rehab & Care Center # 0050310 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	283,754	2.71	5.42	Distribution	\$ 16,246	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	\$ 16,246		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' COMPILATION REPORT

Facility Name & ID Number Hillside Rehab & Care Center

0050310

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization 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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	Utilities	Resident Days	332,289	13	\$ 671	\$ 17,995	\$ 36	1	
2	10	Nursing & Medical Records	Resident Days	332,289	13	175,140	175,140	17,995	9,485	2
3	17	Owners Compensation	Resident Days	332,289	13	300,000	17,995	16,246	3	
4	19	Professional Fees	Resident Days	332,289	13	72,214	17,995	3,911	4	
5	20	Dues, Subscriptions	Resident Days	332,289	13	11,333	17,995	614	5	
6	21	Salaries - Other	Resident Days	332,289	13	1,491,031	1,491,031	17,995	80,746	6
7	21	Clerical & Office Supplies	Resident Days	332,289	13	343,761	17,995	18,616	7	
8	22	Emp Benefits & Payroll Taxes	Resident Days	332,289	13	346,778	17,995	18,780	8	
9	24	Seminars	Resident Days	332,289	13	66,551	17,995	3,604	9	
10	25	Admin Staff Travel	Resident Days	332,289	13	98,168	17,995	5,316	10	
11	26	Insurance	Resident Days	332,289	13	20,457	17,995	1,108	11	
12	30	Depreciation	Resident Days	332,289	13	31,136	17,995	1,686	12	
13	33	Real Estate Taxes	Resident Days	332,289	13	263	17,995	14	13	
14	34	Building Rent	Resident Days	332,289	13	94,122	17,995	5,097	14	
15	34	Rental - Storage Unit	Resident Days	332,289	13	7,741	17,995	419	15	
16	35	Equipment Rental	Resident Days	332,289	13	8,255	17,995	447	16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS				\$ 3,067,621	\$ 1,666,171		\$ 166,125	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hillside Rehab & Care Center

0050310

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	21	Clerical & Office Supplies	Revenue	7	\$ 679	\$	29,200	\$ 165	1
2	30	Depreciation	Revenue	7	20,624		29,200	5,025	2
3	34	Building Rent	Revenue	7	6,237		29,200	1,520	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 27,540	\$		\$ 6,710	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hillside Rehab & Care Center

0050310

Report Period Beginning:

01/01/15

Ending:

12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
	A. Directly Facility Related																
	Long-Term																
1							\$	\$			\$	1					
2												2					
3												3					
4												4					
5												5					
	Working Capital																
6	MidCap Funding I, LLC		X	Line of Credit		10/22/09				Variable	2,778	6					
7												7					
8												8					
9	TOTAL Facility Related							\$	\$			\$ 2,778	9				
	B. Non-Facility Related*																
10	Interest Income Offset		X								(611)	10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related							\$	\$			\$ (611)	14				
15	TOTALS (line 9+line14)							\$	\$			\$ 2,167	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' COMPILATION REPORT

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																	
1. Real Estate Tax accrual used on 2014 report.		\$	54,302	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.)		\$	(2,739)	2															
3. Under or (over) accrual (line 2 minus line 1).		\$	(57,041)	3															
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	112,972	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.		\$	55,931	7															
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2010	<u>56,556</u>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2014 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2014 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2014 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2011	<u>54,071</u>	9																
	2012	<u>51,866</u>	10																
	2013	<u>52,720</u>	11																
	2014	<u>58,954</u>	12																
55,931 Line 7, Real Estate Tax Portion of Lease Payments																			
14 Bridgemark Healthcare Allocation																			
55,945 Total Schedule V, Line 33																			

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' COMPILATION REPORT

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Hillside Rehab & Care Center COUNTY Kendall
 FACILITY IDPH LICENSE NUMBER 0050310
 CONTACT PERSON REGARDING THIS REPORT Michael Parentin
 TELEPHONE (314) 431-0511 FAX #: (314) 754-9176

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2014 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 2014.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>02-29-278-017</u>	<u>Lot 1 Unit 13 Countryside Sub</u>	\$ <u>51,812.20</u>	\$ <u>51,812.20</u>
2. <u>02-29-278-008</u>	<u>Sec 29-37-7</u>	\$ <u>4,137.26</u>	\$ <u>4,137.26</u>
3. <u>02-29-278-018</u>	<u>Lot 12 Unit 1 & Lot 16 Unit 2</u>	\$ <u>3,004.42</u>	\$ <u>3,004.42</u>
4. _____	<u>Countryside Sub</u>	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>58,953.88</u></u>	\$ <u><u>58,953.88</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

Facility Name & ID Number Hillside Rehab & Care Center

0050310 Report Period Beginning:

01/01/15 Ending:

12/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,390 B. General Construction Type: Exterior Masonry Frame Brick Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hillside Rehab & Care Center

0050310

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Therapy Door		2009	1,630	109	15	109		715	9
10	Wallcovering, Shower Room Remodel, Nurses Station & Entryway		2009	15,951	1,063	15	1,063		6,646	10
11	Carpet		2009	3,509		5			3,509	11
12	Concrete		2009	3,500	233	15	233		1,419	12
13	Carpet		2009	3,389		5			3,389	13
14	Hallway Wing 1-paint, crown molding		2010	5,752	383	15	383		2,269	14
15	Oakwall Cabinets for Nurses Station		2010	1,163	78	15	78		452	15
16	Reception Area - Countertop, paint, oakwork, drywall		2010	5,127	342	15	342		1,937	16
17	Shower Room W1 Heater, Fire System Installation		2010	2,854	190	15	190		1,078	17
18	Shower Room W1 Heater, Fire System Installation		2010	2,854	190	15	190		1,078	18
19	4 Ton A/C Unit & install		2010	3,155	316	10	316		1,762	19
20	Carpet		2010	3,473	405	5	405		3,473	20
21	Concrete Work (Drainage: W1, W2, Main)		2010	7,000	350	20	350		1,867	21
22	Hallway Wing 2-paint crown molding		2010	4,836	322	15	322		1,719	22
23	Facility Signage - In building		2010	3,725	372	10	372		1,925	23
24	Dining Room - Paint, tile, lights/blinds		2010	3,426	228	15	228		1,180	24
25	Beauty Show - Crown Molding, carpet tile, cabinet, light fixtures & paint		2011	2,648	177	15	177		883	25
26	Garage - Flooring, electrical work, drywall, insulation & paint		2011	6,873	458	15	458		2,177	26
27	Fire Rated Doors & Fire Alarm Control Panel		2011	25,494	2,506	15	2,506		10,484	27
28	Water Heater		2012	1,365	137	10	137		523	28
29	Fans for ARCH Unit		2013	1,153	115	10	115		269	29
30	Blinds for ARCH Unit		2013	1,820	364	5	364		849	30
31	Hillside Welcome Sign		2013	1,290	129	10	129		301	31
32	Cabinets for ARCH unit		2013	2,843	190	15	190		442	32
33	Drapes/paint for ARCH unit		2013	4,880	976	5	976		2,277	33
34	Flooring/Sink/Mirror for ARCH Unit		2013	6,011	601	10	601		1,402	34
35	Materials/Labor/Supplies for ARCH Unit		2013	32,364	2,158	15	2,158		5,034	35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hillside Rehab & Care Center

0050310

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	
37	Vanities/Shower/Blumbing	2013	\$ 6,004	\$ 300	20	\$ 300	\$	\$ 625	37
38	Doors for ARCH Unit	2013	4,053	270	15	270		630	38
39	Air Conditioner	2013	2,010	201	10	201		519	39
40	Valances, paint, wall covering, exit lights, new walls, floor								40
41	(cont.) finishes, windows for new therapy room	2014	12,814	994	15	994		1,506	41
42	Cabinets for Therapy Room	2014	2,306	154	15	154		231	42
43	Flooring for new dining room	2014	1,261	84	15	84		119	43
44	windows & wall coverings for Kitchen remodel	2014	2,295	153	15	153		191	44
45	New Windows	2014	1,765	176	10	176		191	45
46	2 A/C Units	2014	1,650	330	5	330		523	46
47	New Flooring for Wing 1 & Wing 2	2015	4,020	112	15	112		112	47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63	Related Party Allocation - Bridgemark HealthcareLLC								63
64	New Office Build-Out	2011	7,355		20	389	389	1,734	64
65	Conference Room Chair Rail & Paint	2012	83		5	17	17	56	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 203,701	\$ 15,166		\$ 15,572	\$ 406	\$ 65,496	70

SEE ACCOUNTANTS' COMPILATION 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	\$ 158,637	\$ 13,569	\$ 19,853	\$ 6,284	3-10	\$ 62,893	71
72	Current Year Purchases	6,600	177	198	21	3-10	198	72
73	Fully Depreciated Assets	18,140					18,140	73
74								74
75	TOTALS	\$ 183,377	\$ 13,746	\$ 20,051	\$ 6,305		\$ 81,231	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			720				4	720	77
78										78
79										79
80	TOTALS			\$ 720	\$	\$	\$		\$ 720	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)	\$ 387,798	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 28,912	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 35,623	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,711	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 147,447	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' COMPILATION REPORT

Facility Name & ID Number Hillside Rehab & Care Center

0050310

Report Period Beginning: 01/01/15

Ending: 12/31/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Elite Yorkville, LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		<u>79</u>		\$ <u>392,276</u>			3
4	Additions							4
5	<u>Related Party Allocation - Bridgemark</u>				<u>7,036</u>			5
6	<u>Storage Rental</u>				<u>1,370</u>			6
7	TOTAL		79		\$ 400,682			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

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

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: \$ 19,775

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Section N/A</u>		\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hillside Rehab & Care Center # 0050310 Report Period Beginning: 01/01/15 Ending: 12/31/15
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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' COMPILATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1		
2	Licensed Speech and Language Development Therapist		hrs							2		
3	Licensed Recreational Therapist		hrs							3		
4	Licensed Physical Therapist	10a,2	hrs				292		292	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				153,493		153,493	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					4,172		4,172	12		
13	Other (specify): <u>X-Ray, Labs, Therapy</u>	39,3					377,025		377,025	13		
14	TOTAL			\$		\$	377,025	\$	157,957	\$	534,982	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' COMPILATION REPORT

Facility Name & ID Number Hillside Rehab & Care Center

0050310

Report Period Beginning: 01/01/15

Ending:

12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15 (last day of reporting year)

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	\$ 4,085	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (72,001))	320,145		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	60,492		7
8	Accounts Receivable (owners or related parties)	847,524		8
9	Other(specify): <u>Deposits</u>	59,824		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,292,070	\$	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	213,108		15
16	Equipment, at Historical Cost	112,019		16
17	Accumulated Depreciation (book methods)	(99,086)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	110,233		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 336,274	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,628,344	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 783,353	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	48,927		30
31	Accrued Taxes Payable (excluding real estate taxes)	678		31
32	Accrued Real Estate Taxes(Sch.IX-B)	112,972		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accrued provider taxes</u>	21,844		36
37	<u>Due to other related parties</u>	1,412		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 969,186	\$	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)	\$ 969,186	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 659,158	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,628,344	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,131,683	1
2	Restatements (describe):		2
3	Prior Year Adjustment for Workers Comp Audit	(124,637)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,007,046	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(347,888)	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)	\$ (347,888)	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)	\$ 659,158	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 3,895,454	1
2	Discounts and Allowances for all Levels	(61,055)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,834,399	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	63,410	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 63,410	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	213	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	70	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	2,850	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,133	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	611	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 611	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Attached Schedule</u>	3,027	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,027	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,904,580	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	864,229	31
32	Health Care	1,272,111	32
33	General Administration	915,914	33
B. Capital Expense			
34	Ownership	533,639	34
C. Ancillary Expense			
35	Special Cost Centers	534,689	35
36	Provider Participation Fee	131,886	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,252,468	40
41	Income before Income Taxes (line 30 minus line 40)**	(347,888)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (347,888)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 995,132	44
45	Private Pay - Net Inpatient Revenue	1,062,125	45
46	Medicare - Net Inpatient Revenue	1,202,726	46
47	Other-(specify) <u>Insurance</u>	390,244	47
48	Other-(specify) <u>Hospice</u>	184,171	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,834,399	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' COMPILATION REPORT

Facility Name & ID Number Hillside Rehab & Care Center

0050310

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	1,900	2,067	\$ 76,253	\$ 36.89	1
2	Assistant Director of Nursing					2
3	Registered Nurses	15,518	16,347	457,100	27.96	3
4	Licensed Practical Nurses	2,747	2,933	76,667	26.14	4
5	CNAs & Orderlies	36,755	39,393	439,617	11.16	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,321	2,530	40,169	15.88	10
11	Social Service Workers	2,374	2,374	31,055	13.08	11
12	Dietician					12
13	Food Service Supervisor	2,146	2,197	54,007	24.58	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,503	10,015	121,744	12.16	15
16	Dishwashers					16
17	Maintenance Workers	1,924	2,109	42,726	20.26	17
18	Housekeepers	8,469	9,350	111,680	11.94	18
19	Laundry					19
20	Administrator	1,994	2,225	81,796	36.76	20
21	Assistant Administrator					21
22	Other Administrative	945	1,078	37,834	35.10	22
23	Office Manager	1,844	2,104	44,369	21.09	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	88,440	94,722	\$ 1,615,017 *	\$ 17.05	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 9,924	1,3	35
36	Medical Director	19,400	9,3	36
37	Medical Records Consultant	895	10,3	37
38	Nurse Consultant			38
39	Pharmacist Consultant	150	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	1,668	11,3	44
45	Social Service Consultant	567	12,3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 32,604		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' COMPILATION REPORT

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	Schedule N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hillside Rehab & Care Center# 0050310

Report Period Beginning:

01/01/15

Ending:

12/31/15**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 \$2,725
- (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? 3-5 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 25,073 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. \$ 131,886
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? None Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.

Hillside Rehab & Care Center
Attachment to Schedule XII B
Equipment Rentals
12/31/2015

<u>Description</u>		
16A	Nursing Equipment	13,515
16B	Copier Lease	4,300
16C	Dietary Equipment	1,513
16D	Related Party Allocation - Bridgemark Healthcare	447
		<u>19,775</u>

Hillside Rehab & Care Center
Attachment to Schedule XVII I. Revenue
Other Income
12/31/2015

Description		
28A	Mattress Rental	495
28B	Medical Record Copies	100
28C	Miscellaneous	2,432
		<u>3,027</u>