

Facility Name & ID Number Montgomery Nrsg & Rehab Ctr

0053454 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	110	Skilled (SNF)	110	40,150	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	110	TOTALS	110	40,150	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	20,693	8,840	4,973	34,506	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,693	8,840	4,973	34,506	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.94%

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 4,331

Medicare Intermediary Novitas Solutions

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Montgomery Nrsg & Rehab Ctr # 0053454 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	263,849	14,982	9,769	288,600		288,600		288,600		1
2	Food Purchase		233,852		233,852		233,852	(297)	233,555		2
3	Housekeeping	124,120	40,463	318	164,901		164,901		164,901		3
4	Laundry	58,078	15,679	500	74,257		74,257		74,257		4
5	Heat and Other Utilities			145,395	145,395		145,395	(34,107)	111,288		5
6	Maintenance	80,435	22,960	101,798	205,193		205,193		205,193		6
7	Other (specify):*										7
8	TOTAL General Services	526,482	327,936	257,780	1,112,198		1,112,198	(34,404)	1,077,794		8
	B. Health Care and Programs										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	1,785,151	151,177	41,126	1,977,454		1,977,454	31,280	2,008,734		10
10a	Therapy		623		623		623		623		10a
11	Activities	73,179	6,392	6,242	85,813		85,813		85,813		11
12	Social Services	51,684		569	52,253		52,253		52,253		12
13	CNA Training					2,460	2,460		2,460		13
14	Program Transportation			11,713	11,713	7,178	18,891		18,891		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,910,014	158,192	69,250	2,137,456	9,638	2,147,094	31,280	2,178,374		16
	C. General Administration										
17	Administrative	109,409		342,500	451,909		451,909	(158,931)	292,978		17
18	Directors Fees										18
19	Professional Services			20,695	20,695		20,695	21,142	41,837		19
20	Dues, Fees, Subscriptions & Promotions			204,813	204,813		204,813	(65,264)	139,549		20
21	Clerical & General Office Expenses	100,485	28,263	92,067	220,815		220,815	185,396	406,211		21
22	Employee Benefits & Payroll Taxes			368,992	368,992		368,992	102,912	471,904		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,611	3,611	(2,460)	1,151	12,961	14,112		24
25	Other Admin. Staff Transportation			22,490	22,490	(7,178)	15,312	21,243	36,555		25
26	Insurance-Prop.Liab.Malpractice			91,523	91,523		91,523	3,474	94,997		26
27	Other (specify):*										27
28	TOTAL General Administration	209,894	28,263	1,146,691	1,384,848	(9,638)	1,375,210	122,933	1,498,143		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,646,390	514,391	1,473,721	4,634,502		4,634,502	119,809	4,754,311		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.

Facility Name & ID Number

Montgomery Nrsg & Rehab Ctr

#0053454

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

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			9,230	9,230		9,230	1,992	11,222			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,211	9,211		9,211	6,005	15,216			32
33	Real Estate Taxes			56,464	56,464		56,464	26	56,490			33
34	Rent-Facility & Grounds			678,592	678,592		678,592	9,429	688,021			34
35	Rent-Equipment & Vehicles			56,970	56,970		56,970	886	57,856			35
36	Other (specify):*											36
37	TOTAL Ownership			810,467	810,467		810,467	18,338	828,805			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		164,648	698,959	863,607		863,607	(256,593)	607,014			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			246,949	246,949		246,949		246,949			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		164,648	945,908	1,110,556		1,110,556	(256,593)	853,963			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,646,390	679,039	3,230,096	6,555,525		6,555,525	(118,446)	6,437,079			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.)

		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	(34,407)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(297)	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	(275)	20		17
18	Fines and Penalties				18
19	Entertainment	(4,478)	21		19
20	Contributions	(3,330)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(61,742)	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	(4,332)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (108,861)		\$	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)	(9,585)	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (9,585)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (118,446)		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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' PREPARATION REPORT

Montgomery Nrsrg & Rehab Ctr

ID# 0053454

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	To Eliminate Gifts & Flowers	\$ (3,656)	20	1
2	To Eliminate Lobbying & PAC Dues	(2,666)	20	2
3	Addition of 2017 IDPH License paid in 2016	1,990	20	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	(4,332)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Montgomery Nrsg & Rehab Ctr# 0053454

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(297)	0	0	0	0	0	0	0	0	0	0	(297)	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	(34,407)	300	0	0	0	0	0	0	0	0	0	(34,107)	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	(34,704)	300	0	0	0	0	0	0	0	0	0	(34,404)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	31,261	19	0	0	0	0	0	0	0	0	31,280	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	0	31,261	19	0	31,280	16							
	C. General Administration													
17	Administrative	0	(268,368)	109,437	0	0	0	0	0	0	0	0	(158,931)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	21,142	0	0	0	0	0	0	0	0	0	21,142	19
20	Fees, Subscriptions & Promotions	(66,349)	1,049	36	0	0	0	0	0	0	0	0	(65,264)	20
21	Clerical & General Office Expenses	(7,808)	185,154	8,050	0	0	0	0	0	0	0	0	185,396	21
22	Employee Benefits & Payroll Taxes	0	26,727	76,185	0	0	0	0	0	0	0	0	102,912	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	8,633	4,328	0	0	0	0	0	0	0	0	12,961	24
25	Other Admin. Staff Transportation	0	8,858	12,385	0	0	0	0	0	0	0	0	21,243	25
26	Insurance-Prop.Liab.Malpractice	0	2,549	925	0	0	0	0	0	0	0	0	3,474	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(74,157)	(14,256)	211,346	0	122,933	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(108,861)	17,305	211,365	0	119,809	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Montgomery Nrsg & Rehab Ctr

0053454

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	1,992	0	0	0	0	0	0	0	0	0	1,992	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	6,005	0	0	0	0	0	0	0	0	6,005	32
33	Real Estate Taxes	0	26	0	0	0	0	0	0	0	0	0	26	33
34	Rent-Facility & Grounds	0	9,429	0	0	0	0	0	0	0	0	0	9,429	34
35	Rent-Equipment & Vehicles	0	0	886	0	0	0	0	0	0	0	0	886	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	11,447	6,891	0	0	0	0	0	0	0	0	18,338	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	(256,593)	0	0	0	0	0	0	0	0	(256,593)	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	(256,593)	0	0	0	0	0	0	0	0	(256,593)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(108,861)	28,752	(38,337)	0	0	0	0	0	0	0	0	(118,446)	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 Belleville	Belleville, IL	Bridgemark Healthcar	St. Louis, 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. Louis, MO	Human Resources
		Helia Healthcare of Champaign	Champaign, IL	Bridgemark Medical S	St. Louis, MO	Medical Supplies
		Helia Healthcare of Energy	Energy, IL	NW Rehab, LLC	St. Louis, MO	Therapy
		Helia Healthcare of Olney	Olney, IL	Mid-South Health Clin	Poplar Bluff, MO	Clinic
		Helia Healthcare of Greenville	Greenville, IL			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	5 Utilities	\$	Bridgemark Healthcare, LLC	100.00%	\$ 300	\$	300	1
2	V	10 Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	31,261		31,261	2
3	V	17 Management Fees	342,500	Bridgemark Healthcare, LLC	100.00%	74,132		(268,368)	3
4	V	19 Professional Services		Bridgemark Healthcare, LLC	100.00%	21,142		21,142	4
5	V	20 Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	1,049		1,049	5
6	V	21 Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	185,154		185,154	6
7	V	22 Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	26,727		26,727	7
8	V	24 Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	8,633		8,633	8
9	V	25 Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	8,858		8,858	9
10	V	26 Insurance		Bridgemark Healthcare, LLC	100.00%	2,549		2,549	10
11	V	30 Depreciation		Bridgemark Healthcare, LLC	100.00%	1,992		1,992	11
12	V	33 Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	26		26	12
13	V	34 Rent		Bridgemark Healthcare, LLC	100.00%	9,429		9,429	13
14	Total		\$ 342,500			\$ 371,252	\$ *	28,752	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%	\$ 886	\$ 886	15
16	V							16
17	V							17
18	V	10 Nursing & Med		NW Rehab, LLC	100.00%	19	19	18
19	V	39 Therapy	682,364	NW Rehab, LLC	100.00%	425,771	(256,593)	19
20	V	17 Admin Salaries		NW Rehab, LLC	100.00%	109,437	109,437	20
21	V	20 Dues & Subscriptions		NW Rehab, LLC	100.00%	36	36	21
22	V	21 Clerical & Office Supplies		NW Rehab, LLC	100.00%	8,050	8,050	22
23	V	22 Employee Benefits		NW Rehab, LLC	100.00%	76,185	76,185	23
24	V	24 Travel & Seminar		NW Rehab, LLC	100.00%	4,328	4,328	24
25	V	25 Other Admin Transp		NW Rehab, LLC	100.00%	12,385	12,385	25
26	V	26 Insurance - Prop, Liab, Malprac		NW Rehab, LLC	100.00%	925	925	26
27	V	32 Interest		NW Rehab, LLC	100.00%	6,005	6,005	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		\$ 682,364			\$ 644,027	\$ * (38,337)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Montgomery Nrsg & Rehab Ctr

0053454

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

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			Frankfort Healthcare & Rehab	West Frankfort, IL				1
2			Helia Southbelt Healthcare	Belleville, IL				2
3			Hillside Rehab & Care Center	Yorkville, IL				3
4			Helia Healthcare of Jerseyville	Jerseyville, IL				4
5			Heia Healthcare of Poplar Bluff	Poplar Bluff, MO				5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Montgomery Nrsg & Rehab Ctr # 0053454 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	702,656	4.77	9.54	Distribution	\$ 74,132	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	\$ 74,132		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 Nrsng & Rehab Ctr

0053454

Report Period Beginning:

01/01/2017

Ending: 2/31/2017

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) 457-9176

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	361,568	13	\$ 3,142	\$ 34,506	\$ 300	1	
2	10	Nursing & Medical Supplies	Resident Days	361,568	13	327,569	327,569	34,506	31,261	2
3	17	Owner's Compensation	Resident Days	361,568	13	776,788	34,506	74,132	3	
4	19	Professional Fees	Resident Days	361,568	13	221,539	34,506	21,142	4	
5	20	Dues, Subscriptions	Resident Days	361,568	13	10,991	34,506	1,049	5	
6	21	Salaries - Other	Resident Days	361,568	13	1,561,133	1,561,133	34,506	148,986	6
7	21	Clerical & Office Supplies	Resident Days	361,568	13	378,981	34,506	36,168	7	
8	22	Emp Benefits & Payroll Taxes	Resident Days	361,568	13	280,058	34,506	26,727	8	
9	24	Seminars	Resident Days	361,568	13	90,455	34,506	8,633	9	
10	25	Admin Staff Travel	Resident Days	361,568	13	92,816	34,506	8,858	10	
11	26	Insurance	Resident Days	361,568	13	26,711	34,506	2,549	11	
12	30	Depreciation	Resident Days	361,568	13	20,874	34,506	1,992	12	
13	33	Real Estate Taxes	Resident Days	361,568	13	269	34,506	26	13	
14	34	Building Rent	Resident Days	361,568	13	95,732	34,506	9,136	14	
15	34	Rental - Storage	Resident Days	361,568	13	3,073	34,506	293	15	
16	35	Equipment Rental	Resident Days	361,568	13	9,286	34,506	886	16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 3,899,417	\$ 1,888,702	\$ 372,138	25	

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Montgomery Nrsg & Rehab Ctr

0053454

Report Period Beginning:

01/01/2017

Ending: 2/31/2017

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 NW Rehab, LLC
 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	10	Nursing & Med	Revenue	2,581,783	19	\$ 73	\$ 682,364	\$ 19	1	
2	39	Therapy	Revenue	2,581,783	19	1,610,941	1,610,941	682,364	425,771	2
3	17	Admin Salaries	Revenue	2,581,783	19	414,064	414,064	682,364	109,437	3
4	20	Dues & Subscriptions	Revenue	2,581,783	19	136	682,364	682,364	36	4
5	21	Clerical & Office Supplies	Revenue	2,581,783	19	30,456	682,364	682,364	8,050	5
6	22	Employee Benefits	Revenue	2,581,783	19	288,251	682,364	682,364	76,185	6
7	24	Travel & Seminar	Revenue	2,581,783	19	16,377	682,364	682,364	4,328	7
8	25	Other Admin Transportation	Revenue	2,581,783	19	46,860	682,364	682,364	12,385	8
9	26	Insurance - Prop Liab, Malprac	Revenue	2,581,783	19	3,500	682,364	682,364	925	9
10	32	Interest	Revenue	2,581,783	19	22,721	682,364	682,364	6,005	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,433,379	\$ 2,025,005	\$ 643,141		25

SEE ACCOUNTANTS' PREPARATION REPORT

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Montgomery Nrsg & 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 2016 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 2016.

(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>46,326.28</u>	\$ <u>46,326.28</u>
2. _____	<u>Taylor Springs 8-4-716 3/4 S13</u>	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>46,326.28</u></u>	\$ <u><u>46,326.28</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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 Brick Frame Steel & 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.

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

*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 Nrsg & Rehab Ctr# 0053454

Report Period Beginning:

01/01/2017 Ending: 12/31/2017**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	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 Lights	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 and 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 and 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 Nrsg & Rehab Ctr# 0053454

Report Period Beginning:

01/01/2017 Ending: 12/31/2017**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	Exhaust Fan Replacement	2007	3,862						2
3	Interior Remodeling - Shower Room	2007	20,896						3
4	Water Heaters	2007	10,972						4
5	Doors - Metal	2007	4,450						5
6	Air Conditioning Units	2007	3,512						6
7	Flooring	2007	10,399						7
8	Landscaping - Sign Area	2007	2,575						8
9	Repared Driveway	2007	4,750						9
10	Flooring	2008	132,076						10
11	Wallpapering	2008	45,923						11
12	Electrical Work	2008	11,765						12
13	5 A/C Units & Installation	2008	8,021						13
14	Facility Signage	2008	8,602						14
15	8 Oak Doors	2008	4,659						15
16	In Wall Fountain - Labor & Materials	2008	5,321						16
17	Handrails & Hardware	2008	8,950						17
18	Cabinets, Countertops, & Sinks	2008	28,200						18
19	5 Shaped Cornices	2008	3,034						19
20	Cabinet Installation	2008	3,320						20
21	3 A/C Units	2009	1,839						21
22	Sinks/Faucets - Resident Rooms	2009	2,985						22
23	Generator	2009	50,432						23
24	Roof Replacement - 100 & 400 Halls	2009	36,200						24
25	10 Upholstered Cornices	2009	5,255						25
26	Wi-Fi Access Installation	2009	1,892						26
27	Ceiling Tiles - Therapy Room	2009	676						27
28	Plexiglass for Maint. Shed	2009	758						28
29	Closet Doors	2009	548						29
30	New Entry Door	2010	3,000						30
31	4 AC/Heat Units	2010	2,618						31
32	Neww 400 Amp Breaker	2010	1,787						32
33	Flooring	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 Nrsg & Rehab Ctr# 0053454

Report Period Beginning:

01/01/2017 Ending: 12/31/2017**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	Insulate Duct Work	2010	14,800						2
3	Kitchen Flooring	2011	4,520						3
4	Breaker Panel & Installation	2011	10,994						4
5	Sprinkler System	2011	117,500						5
6	6 AC/Heat Units	2011	4,502						6
7	Motion Sensor/Detectors	2011	1,094						7
8	Water Heaters	2011	1,145						8
9	Sidewalks	2011	3,850						9
10	Vinyl Fence and Gate	2011	5,325						10
11	Asphalt/Seal/Stripe/Patch & Repair Parking Lot	2011	28,870						11
12	Drainage Downspouts Installation	2011	2,880						12
13	Windows - Remove and Replace	2012	9,480						13
14	Flooring - Shower Room	2012	4,602						14
15	Flooring - Lunch Room	2012	1,783						15
16	2 Electric Heater/AC Units	2012	1,605						16
17	Security Locks	2012	7,870						17
18	Light Fixtures - Weather Proof	2012	4,471						18
19	100 Gal. Hot Water Heater	2012	8,042						19
20	10 AC/Heat Units	2013	7,491						20
21	New Breaker for Lighting	2013	2,466						21
22	Nurse Call System Upgrade	2013	7,082						22
23	Electrical Work - 2 New Circuits	2013	1,615						23
24	5 New Vinyl Doors	2013	765						24
25	Hot Water Heater (10 Gal.) & Missing Valve	2013	2,239						25
26	5 Ton 13 Seer Rooftop A/C Unit	2013	6,071						26
27	400 & 500 Half Light Fixtures	2013	3,195						27
28	Plumbing for Stool & Lavatory	2013	2,457						28
29	Lighting Receptacles, fixtures, and ballasts	2014	5,418						29
30	New Cabinets, handles, and locks	2014	10,075						30
31	Relief Valve on Sprinkler System	2014	1,565						31
32	A/C Units	2014	10,016						32
33	Electrical Work	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.

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	
1	Totals from Page 12C, Carried Forward		\$ 2,184,160	\$		\$	\$	\$	1
2	23 Wood Dors	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									9
10	Heating/Cooling System	2015	6,799	1,360	5	1,360		3,173	10
11	Replaced Toilets, Sinks, Water Supplies in all Bathrooms	2017	20,778	693	10	693		693	11
12	Painted and Replaced Plumbing in all Shower Rooms	2017	4,353	181	10	181		181	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20	Related Party Allocation - Bridgemark:								20
21	New Office Build Out	2011	12,962		20	686	686	4,429	21
22	Conference Rm Chair Rail & Paint	2012	147		5	20	20	147	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,248,644	\$ 2,234		\$ 2,940	\$ 706	\$ 8,623	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 Nrsg & Rehab Ctr

0053454

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

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	\$ 34,973	\$ 5,250	\$ 6,536	\$ 1,286	3-15	\$ 14,958	71
72	Current Year Purchases	11,874	725	725		3-15	725	72
73	Fully Depreciated Assets	8,970					8,970	73
74								74
75	TOTALS	\$ 55,817	\$ 5,975	\$ 7,261	\$ 1,286		\$ 24,653	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	\$ 1,021	\$ 1,021		4	\$ 1,021	76
77	Related Party Allocation - Bridgemark			1,268				4	1,268	77
78										78
79										79
80	TOTALS			\$ 8,268	\$ 1,021	\$ 1,021			\$ 2,289	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)	\$ 2,340,402	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 9,230	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 11,222	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,992	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 35,565	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	Section N/A	\$	92
93			93
94			94
95		\$	95

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Aviv, LLC

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

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>110</u>		\$ <u>676,795</u>			3
4	Additions						4
5	Storage Rental			<u>1,797</u>			5
6	Related Party Allocation - Bridgemark			<u>9,429</u>			6
7	TOTAL	<u>110</u>		\$ <u>688,021</u>			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.	<u>/2018</u>	\$ _____
13.	<u>/2019</u>	\$ _____
14.	<u>/2020</u>	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 57,856 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' PREPARATION REPORT

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 checked="" type="checkbox"/> YES <input 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. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		798		798
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments		1,260		1,260
8	CNA Competency Tests		402		402
9	TOTALS	\$	\$ 2,460	\$	\$ 2,460
10	SUM OF line 9, col. 1 and 2 (e)	\$	2,460		

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	6
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	6

- (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.)

	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				623		623	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				140,987		140,987	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					23,661		23,661	12
13	Other (specify): <u>X-Ray, Labs, Therapy</u>	39,8				442,366			442,366	13
14	TOTAL			\$		\$ 442,366	\$ 165,271		\$ 607,637	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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2017

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 4,790	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>254,592</u>)	1,062,181		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	280,745		8
9	Other(specify): <u>Deposits</u>	163,839		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,511,555	\$	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	31,930		15
16	Equipment, at Historical Cost	44,565		16
17	Accumulated Depreciation (book methods)	(14,970)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	61,607		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 123,132	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,634,687	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 942,056	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	206,870		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,760		31
32	Accrued Real Estate Taxes(Sch.IX-B)	61,607		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Assessment Tax</u>	31,952		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,254,245	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	54,802		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)	\$ 54,802	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,309,047	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 325,640	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,634,687	\$	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 172,045	1
2	Restatements (describe):		2
3	Prior Year Adjustment after Cost Report was Issued	20	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 172,065	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	153,575	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)	\$ 153,575	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)	\$ 325,640	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Montgomery Nrsng & Rehab Ctr

0053454

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

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	\$ 6,531,254	1
2	Discounts and Allowances for all Levels	(143,388)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,387,866	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	320,912	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 320,912	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***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous</u>	322	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 322	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,709,100	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,112,198	31
32	Health Care	2,137,456	32
33	General Administration	1,384,848	33
B. Capital Expense			
34	Ownership	810,467	34
C. Ancillary Expense			
35	Special Cost Centers	863,607	35
36	Provider Participation Fee	246,949	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,555,525	40
41	Income before Income Taxes (line 30 minus line 40)**	153,575	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 153,575	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,897,793	44
45	Private Pay - Net Inpatient Revenue	1,308,109	45
46	Medicare - Net Inpatient Revenue	2,008,205	46
47	Other-(specify) <u>Insurance</u>	141,735	47
48	Other-(specify) <u>Hospice</u>	32,024	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,387,866	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

Facility Name & ID Number Montgomery Nrsg & Rehab Ctr

0053454

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,024	2,193	\$ 81,533	\$ 37.18	1
2	Assistant Director of Nursing	1,892	2,120	61,711	29.11	2
3	Registered Nurses	5,931	6,419	190,759	29.72	3
4	Licensed Practical Nurses	19,864	22,149	446,755	20.17	4
5	CNAs & Orderlies	76,581	82,545	966,486	11.71	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,149	6,390	73,179	11.45	10
11	Social Service Workers	1,718	1,989	51,684	25.98	11
12	Dietician					12
13	Food Service Supervisor	1,455	1,666	36,604	21.97	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,945	20,543	227,245	11.06	15
16	Dishwashers					16
17	Maintenance Workers	4,668	5,335	80,435	15.08	17
18	Housekeepers	11,159	11,882	124,120	10.45	18
19	Laundry	5,139	5,800	58,078	10.01	19
20	Administrator	1,933	2,157	109,409	50.72	20
21	Assistant Administrator					21
22	Other Administrative	2,001	2,182	26,137	11.98	22
23	Office Manager	2,320	2,605	74,348	28.54	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	2,203	2,400	37,907	15.79	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	163,982	178,375	\$ 2,646,390 *	\$ 14.84	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	\$ 9,769	1,3	35
36	Medical Director	9,600	9,3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	11,169	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	6,242	11,3	44
45	Social Service Consultant	569	12,3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 37,349		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Carla Vonder Haar</u>	<u>Administrator</u>	<u>0</u>	\$ <u>109,409</u>	<u>Workers' Compensation Insurance</u>	\$ <u>80,436</u>	<u>IDPH License Fee</u>	\$ <u>1,990</u>	
				<u>Unemployment Compensation Insurance</u>	<u>48,292</u>	<u>Advertising: Employee Recruitment</u>	<u>3,602</u>	
				<u>FICA Taxes</u>	<u>196,490</u>	<u>Health Care Worker Background Check</u>	<u>1,552</u>	
				<u>Employee Health Insurance</u>	<u>31,578</u>	(Indicate # of checks performed _____)		
				<u>Employee Meals</u>		<u>Patient Background Checks</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Dues & Subscriptions</u>	<u>14,595</u>	
				<u>401(k) Match</u>	<u>7,653</u>	<u>Late Fees</u>	<u>115,626</u>	
				<u>Employee Benefits</u>	<u>909</u>	<u>Miscellaneous Licenses & Fees</u>	<u>1,099</u>	
				<u>Other Employee Insurance</u>	<u>3,634</u>	<u>Advertising</u>	<u>61,742</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>109,409</u>			<u>Related Party Allocations</u>	<u>1,085</u>	
(List each licensed administrator separately.)						<u>Less: Public Relations Expense</u>	(_____)	
B. Administrative - Other				<u>Related Party Allocation - Bridgemark</u>	<u>26,727</u>	<u>Non-allowable advertising</u>	<u>(61,742)</u>	
				<u>Related Party Allocation - NW Rehab</u>	<u>76,185</u>	<u>Yellow page advertising</u>	(_____)	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ <u>471,904</u>	TOTAL (agree to Sch. V, line 20, col. 8)	\$ <u>139,549</u>	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ <u>342,500</u>	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)								
C. Professional Services								
<u>Vendor/Payee</u>	<u>Type</u>		<u>Amount</u>	<u>Description</u>	<u>Line #</u>	<u>Amount</u>	<u>Description</u>	<u>Amount</u>
<u>C.J. Schlosser & Compay, LLC</u>	<u>Accounting Services</u>		\$ <u>1,092</u>	<u>Section N/A</u>		\$ _____	<u>Out-of-State Travel</u>	\$ _____
<u>Personal Planners, LLC</u>	<u>Unemployment Consulting</u>		<u>1,256</u>					
<u>Steven B. Pearlman & Associates</u>	<u>Legal Fees</u>		<u>2,207</u>					
<u>Ashman & Stein</u>	<u>Legal Fees</u>		<u>652</u>				<u>In-State Travel</u>	
<u>Paycom Payroll</u>	<u>Payroll Processing</u>		<u>15,488</u>					
							<u>Seminar Expense</u>	<u>1,151</u>
							<u>Related Party Allocation - Bridgemark</u>	<u>8,633</u>
							<u>Related Party Allocation - NW Rehab</u>	<u>4,328</u>
							<u>Entertainment Expense</u>	(_____)
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>20,695</u>	TOTAL		\$ _____	TOTAL (agree to Sch. V, line 24, col. 8)	\$ <u>14,112</u>
(For legal fee disclosure, see page 39 of instructions)								

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Facility Name & ID Number Montgomery Nrsng & Rehab Ctr# 0053454Report Period Beginning: 01/01/2017Ending: 12/31/2017**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 \$5,078
- (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. \$ 26,624 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. \$ 246,949
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 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
Attachment to Schedule XII B
Equipment Rentals
12/31/2017

Description		
16A	Specialty Bed Rental	43,652
16B	Respiratory Equipment	5,189
16C	Copier Lease	6,263
16D	Related Party Allocation - Bridgemark Healthcare	886
16E	Dietary Equipment	1,866
		<u>57,856</u>