FOR BHF USE

LL1

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

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0053447

Facility Name: Jerseyville Nsg & Rehab Ctr

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

County: Jersey

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

HFS ID Number:

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

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 03/01/2015 to 12/31/2015 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Michael Parentin
(Title) Chief Financial Officer

Paid Preparer

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

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nsg & Rehab Ctr # 0053447 Report Period Beginning: 03/01/2015 Ending: 12/31/2015

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	111	Skilled (SNF)	111	33,966	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	111	TOTALS	111	33,966	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,714	10,971	5,760	29,445	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,714	10,971	5,760	29,445	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.69%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

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 [X] Date 03/01/2015 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 111 and days of care provided 4,879

Medicare Intermediary Novitas Solutions

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nsg & Rehab Ctr # 0053447 Report Period Beginning: 03/01/2015 Ending: 12/31/2015

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	203,005	18,640	6,214	227,859		227,859		227,859			1
2	Food Purchase		224,614		224,614		224,614	(414)	224,200			2
3	Housekeeping	118,241	23,181	359	141,781		141,781		141,781			3
4	Laundry	48,389	12,382		60,771		60,771		60,771			4
5	Heat and Other Utilities			106,356	106,356		106,356	(4,893)	101,463			5
6	Maintenance	38,403	17,136	66,772	122,311		122,311	8	122,319			6
7	Other (specify):*											7
8	TOTAL General Services	408,038	295,953	179,701	883,692		883,692	(5,299)	878,393			8
	B. Health Care and Programs											
9	Medical Director			15,010	15,010		15,010		15,010			9
10	Nursing and Medical Records	1,550,214	92,123	32,924	1,675,261		1,675,261	15,569	1,690,830			10
10a	Therapy		17		17		17		17			10a
11	Activities	28,011	3,334	3,665	35,010		35,010	(1,215)	33,795			11
12	Social Services	42,758		2,120	44,878		44,878		44,878			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,620,983	95,474	53,719	1,770,176		1,770,176	14,354	1,784,530			16
	C. General Administration											
17	Administrative	77,696		300,000	377,696		377,696	(139,181)	238,515			17
18	Directors Fees											18
19	Professional Services			13,390	13,390		13,390	6,399	19,789			19
20	Dues, Fees, Subscriptions & Promotions			37,552	37,552		37,552	(24,538)	13,014			20
21	Clerical & General Office Expenses	74,894	18,894	62,158	155,946		155,946	172,023	327,969			21
22	Employee Benefits & Payroll Taxes			358,342	358,342		358,342	115,545	473,887			22
23	Inservice Training & Education											23
24	Travel and Seminar			856	856		856	6,404	7,260			24
25	Other Admin. Staff Transportation			7,263	7,263		7,263	27,050	34,313			25
26	Insurance-Prop.Liab.Malpractice			101,486	101,486		101,486	1,813	103,299			26
27	Other (specify):*											27
28	TOTAL General Administration	152,590	18,894	881,047	1,052,531		1,052,531	165,515	1,218,046			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,181,611	410,321	1,114,467	3,706,399		3,706,399	174,570	3,880,969			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.

Facility Name & ID Number Jerseyville Nsg & Rehab Ctr #0053447 Report Period Beginning: 03/01/2015 Ending: 12/31/2015

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			1,055	1,055		1,055	2,759	3,814			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,884	12,884		12,884	5,035	17,919			32
33	Real Estate Taxes			69,742	69,742		69,742	23	69,765			33
34	Rent-Facility & Grounds			557,902	557,902		557,902	9,026	566,928			34
35	Rent-Equipment & Vehicles			25,003	25,003		25,003	731	25,734			35
36	Other (specify):*											36
37	TOTAL Ownership			666,586	666,586		666,586	17,574	684,160			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		259,516	660,543	920,059		920,059	(211,774)	708,285			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			168,148	168,148		168,148		168,148			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		259,516	828,691	1,088,207		1,088,207	(211,774)	876,433			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,181,611	669,837	2,609,744	5,461,192		5,461,192	(19,630)	5,441,562			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 Jerseyville Nsg & Rehab Ctr # 0053447 Report Period Beginning: 03/01/2015 Ending: 12/31/2015

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,215)	11		4
5	Telephone, TV & Radio in Resident Rooms	(4,952)	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	(113)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(414)	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	(225)	20		17
18	Fines and Penalties				18
19	Entertainment	(148)	21		19
20	Contributions	(101)	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	(16,746)	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	(8,776)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (32,690)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	13,060	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 13,060		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (19,630)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS **Page 5A**

Jerseyville Nsg & Rehab Ctr

ID# **0053447**

Report Period Beginning: **03/01/2015**

Ending: **12/31/2015**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	To Eliminate Gifts and Flowers	$ (4,553)	20	1
2	To Eliminate Lobbying & PAC Dues	(1,802)	20	2
3	To Eliminate 2016 IDPH License Paid in 2015	(2,421)	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**	(8,776)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Jerseyville Nsg & Rehab Ctr # 0053447 **Report Period Beginning:** 03/01/2015 **Ending:** 12/31/2015

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	(414)	0	0	0	0	0	0	0	0	0	0	(414)	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	(4,952)	59	0	0	0	0	0	0	0	0	0	(4,893)	5
6	Maintenance	0	0	8	0	0	0	0	0	0	0	0	8	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,366)	59	8	0	0	0	0	0	0	0	0	(5,299)	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	15,520	49	0	0	0	0	0	0	0	0	15,569	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,215)	0	0	0	0	0	0	0	0	0	0	(1,215)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(1,215)	15,520	49	0	0	0	0	0	0	0	0	14,354	16
	C. General Administration													
17	Administrative	0	(273,416)	134,235	0	0	0	0	0	0	0	0	(139,181)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	6,399	0	0	0	0	0	0	0	0	0	6,399	19
20	Fees, Subscriptions & Promotions	(25,747)	1,004	205	0	0	0	0	0	0	0	0	(24,538)	20
21	Clerical & General Office Expenses	(249)	162,586	9,686	0	0	0	0	0	0	0	0	172,023	21
22	Employee Benefits & Payroll Taxes	0	30,729	84,816	0	0	0	0	0	0	0	0	115,545	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	5,897	507	0	0	0	0	0	0	0	0	6,404	24
25	Other Admin. Staff Transportation	0	8,699	18,351	0	0	0	0	0	0	0	0	27,050	25
26	Insurance-Prop.Liab.Malpractice	0	1,813	0	0	0	0	0	0	0	0	0	1,813	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(25,996)	(56,289)	247,800	0	0	0	0	0	0	0	0	165,515	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(32,577)	(40,710)	247,857	0	0	0	0	0	0	0	0	174,570	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Jerseyville Nsg & Rehab Ctr **#** 0053447 **Report Period Beginning:** 03/01/2015 **Ending:** 12/31/2015

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

	Capital Expense D. Ownership	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)	
30	Depreciation	0	2,759	0	0	0	0	0	0	0	0	0	2,759	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(113)	0	5,148	0	0	0	0	0	0	0	0	5,035	32
33	Real Estate Taxes	0	23	0	0	0	0	0	0	0	0	0	23	33
34	Rent-Facility & Grounds	0	9,026	0	0	0	0	0	0	0	0	0	9,026	34
35	Rent-Equipment & Vehicles	0	0	731	0	0	0	0	0	0	0	0	731	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(113)	11,808	5,879	0	0	0	0	0	0	0	0	17,574	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	(211,774)	0	0	0	0	0	0	0	0	(211,774)	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	(211,774)	0	0	0	0	0	0	0	0	(211,774)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(32,690)	(28,902)	41,962	0	0	0	0	0	0	0	0	(19,630)	45

Facility Name & ID Number Jerseyville Nsg & Rehab Ctr # 0053447 Report Period Beginning: 03/01/2015 Ending: 12/31/2015

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 Healthcare	St. Louis, MO	Management Co.
		Helia Healthcare of Benton	Benton, IL	Helia Healthcare Services	Benton, IL	Laundry, Maint.
		Frankfort Healthcare & Rehab	West Frankfort, IL	Bridgemark Employer Srvs	St. Louis, MO	Human Resources
		Helia Healthcare of Champaign	Champaign, IL	Bridgemark Medical Supply	St. Louis, MO	Medical Supplis
		Helia Healthcare of Energy	Energy, IL	NW Rehab, LLC	St. Louis, MO	Therapy
		Helia Healthcare of Olney	Olney, IL	Mid-South Health Clinic	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. [X] YES [ ] NO

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

1 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%	$ 59	$ 59	1
2	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	15,520	15,520	2
3	V	17	Management Fees	300,000	Bridgemark Healthcare, LLC	100.00%	26,584	(273,416)	3
4	V	19	Professional Services		Bridgemark Healthcare, LLC	100.00%	6,399	6,399	4
5	V	20	Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	1,004	1,004	5
6	V	21	Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	162,586	162,586	6
7	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	30,729	30,729	7
8	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	5,897	5,897	8
9	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	8,699	8,699	9
10	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	1,813	1,813	10
11	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	2,759	2,759	11
12	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	23	23	12
13	V	34	Rent		Bridgemark Healthcare, LLC	100.00%	9,026	9,026	13
14	Total			$ 300,000			$ 271,098	$ * (28,902)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nsg & Rehab Ctr # 0053447 Report Period Beginning: 03/01/2015 Ending: 12/31/2015

VII. RELATED PARTIES (continued)

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

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

1 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)	
15	V	35	Equipment Rental	$	Bridgemark Healthcare, LLC	100.00%	$ 731	$ 731	15
16	V								16
17	V								17
18	V	6	Maintenance		NW Rehab, LLC	100.00%	8	8	18
19	V	10	Nursing & Med		NW Rehab, LLC	100.00%	49	49	19
20	V	17	Administration		NW Rehab, LLC	100.00%	134,235	134,235	20
21	V	20	Dues & Subscriptions		NW Rehab, LLC	100.00%	205	205	21
22	V	21	Clerical & Office		NW Rehab, LLC	100.00%	9,686	9,686	22
23	V	22	Employee Benefits		NW Rehab, LLC	100.00%	84,816	84,816	23
24	V	24	Travel & Seminar		NW Rehab, LLC	100.00%	507	507	24
25	V	25	Other Admin Transp		NW Rehab, LLC	100.00%	18,351	18,351	25
26	V	32	Interest		NW Rehab, LLC	100.00%	5,148	5,148	26
27	V	39	Ancillary Service Centers	626,825	NW Rehab, LLC	100.00%	415,051	(211,774)	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			$ 626,825			$ 668,787	$ * 41,962	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nsg & Rehab Ctr # 0053447 Report Period Beginning: 03/01/2015 Ending: 12/31/2015

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Helia Southbelt Healthcare	Belleville, IL				1
2			Hillside Rehab & Care Center	Yorkville, IL				2
3			Helia Healthcare of Hillsboro	Hillsboro, IL				3
4			Helia Healthcare of Florissant	Florissant, MO				4
5			Helia 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' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nsg & Rehab Ctr # 0053447 Report Period Beginning: 03/01/2015 Ending: 12/31/2015

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Stephen P. Miller	Owner	Administrative	100.00	273,416	4.43	8.86	Distribution	$ 26,584	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	$ 26,584		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 Jerseyville Nsg & Rehab Ctr # 0053447 Report Period Beginning: 03/01/2015 Ending: 2/31/2015

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 [X] NO [ ]

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

Name of Related Organization: Bridgemark Healthcare, LLC
Street Address: 11970 Borman Drive, Suite 100
City / State / Zip Code: St. Louis, MO 63146
Phone Number: ((314) 431-0511
Fax Number: ((314) 754-9176

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Resident Days	332,289	13	$ 671	$	29,445	$ 59	1
2	10	Nursing & Medical Records	Resident Days	332,289	13	175,140	175,140	29,445	15,520	2
3	17	Owners Compensation	Resident Days	332,289	13	300,000		29,445	26,584	3
4	19	Professional Fees	Resident Days	332,289	13	72,214		29,445	6,399	4
5	20	Dues, Subscriptions	Resident Days	332,289	13	11,333		29,445	1,004	5
6	21	Salaries - Other	Resident Days	332,289	13	1,491,031	1,491,031	29,445	132,124	6
7	21	Clerical & Office Supplies	Resident Days	332,289	13	343,761		29,445	30,462	7
8	22	Emp. Benefits & Payroll Taxes	Resident Days	332,289	13	346,778		29,445	30,729	8
9	24	Seminars	Resident Days	332,289	13	66,551		29,445	5,897	9
10	25	Admin Staff Travel	Resident Days	332,289	13	98,168		29,445	8,699	10
11	26	Insurance	Resident Days	332,289	13	20,457		29,445	1,813	11
12	30	Depreciation	Resident Days	332,289	13	31,136		29,445	2,759	12
13	33	Real Estate Taxes	Resident Days	332,289	13	263		29,445	23	13
14	34	Building Rent	Resident Days	332,289	13	94,122		29,445	8,340	14
15	34	Rental - Storage Unit	Resident Days	332,289	13	7,741		29,445	686	15
16	35	Equipment Rental	Resident Days	332,289	13	8,255		29,445	731	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		$ 271,829	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nsg & Rehab Ctr # 0053447 Report Period Beginning: 03/01/2015 Ending: 2/31/2015

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 [X] NO [ ]

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

Name of Related Organization: N W Rehab, LLC
Street Address:
City / State / Zip Code:
Phone Number: ( )
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Revenue	1,879,170	11	$ 25	$	626,825	$ 8	1
2	10	Nursing & Med	Revenue	1,879,170	11	146		626,825	49	2
3	39	Therapy	Revenue	1,879,170	11	1,244,289	1,244,289	626,825	415,051	3
4	17	Admin Salaries	Revenue	1,879,170	11	402,425	402,425	626,825	134,235	4
5	20	Dues & Subscriptions	Revenue	1,879,170	11	616		626,825	205	5
6	21	Salaries - Other	Revenue	1,879,170	11	678	678	626,825	226	6
7	21	Clerical & Office Supplies	Revenue	1,879,170	11	28,359		626,825	9,460	7
8	22	Employee Benefits	Revenue	1,879,170	11	254,272		626,825	84,816	8
9	24	Travel & Seminar	Revenue	1,879,170	11	1,519		626,825	507	9
10	25	Other Admin Transp	Revenue	1,879,170	11	55,016		626,825	18,351	10
11	32	Interest	Revenue	1,879,170	11	15,434		626,825	5,148	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					$ 2,002,779	$ 1,647,392		$ 668,056	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nsg & Rehab Ctr # 0053447 Report Period Beginning: 03/01/2015 Ending: 12/31/2015

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MidCap Funding I, LLC		X			10/22/09				Variable	12,884	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 12,884	9
	B. Non-Facility Related*											
10	Interest Income Offset		X								(113)	10
11												11
12												12
13	Related Party Allocation - NW Rehab										5,148	13
14	TOTAL Non-Facility Related						$	$			$ 5,035	14
15	TOTALS (line 9+line14)						$	$			$ 17,919	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.)

Facility Name & ID Number Jerseyville Nsg & Rehab Ctr # 0053447 Report Period Beginning: 03/01/2015 Ending: 12/31/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 69,742	2
3. Under or (over) accrual (line 2 minus line 1).		$ 69,742	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 69,742	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	63,388	8
	2011	66,953	9
	2012	76,650	10
	2013	78,413	11
	2014	83,157	12

69,742 Real Estate portion of Lease Payments
23 Bridgemark Healthcare Allocation
69,765 Total, Scheduel V, Line 33

	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

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 Jerseyville Nsg & Rehab Ctr COUNTY Jersey

FACILITY IDPH LICENSE NUMBER 0053447

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-875-004-00	Outlots 59, 62, 63, & 64 S PT Outlot 6	$ 78,593.00	$ 78,593.00
2.	04-208-017-00	S 28 T8 R11 Unplatted Parcels	$ 4,563.86	$ 4,563.86
3.		S&W PT SE 1/4 NE 1/4 Less E PT	$	$
4.		Less .10 ACS for HWY	$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 83,156.86	$ 83,156.86

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 Jerseyville Nsg & Rehab Ctr # 0053447 Report Period Beginning: 03/01/2015 Ending: 12/31/2015

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,823 B. General Construction Type: Exterior Brick & Siding Frame Steel & Brick Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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).

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	158,994	1994	$ 71,664	1
2					2
3	TOTALS	158,994		$ 71,664	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nsg & Rehab Ctr # 0053447 Report Period Beginning: 03/01/2015 Ending: 12/31/2015

XI. OWNERSHIP COSTS (continued)

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

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

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nsg & Rehab Ctr # 0053447 Report Period Beginning: 03/01/2015 Ending: 12/31/2015

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Constr. Of 400 Wing - Contractor Costs	2001	$ 874,589	$		$	$	$	37
38	Const. of 400 Wing - Drawing, Surety Bond & Misc	2001	11,223						38
39	Const. of 400 Wing - Interest & Mortgage Ins. Premium	2001	83,401						39
40	400 Wing - Nurse Call System	2001	10,104						40
41	400 Wing - Cable TV System Cabling	2001	1,962						41
42	400 Wing - Fire Alarm System	2001	13,326						42
43	400 Wing - Door Monitoring System	2001	2,640						43
44	400 Wing - TV Wall Mounts	2001	5,851						44
45	400 Wing - Signage	2001	1,161						45
46	400 Wing - Handrails & Wal lGuards	2001	2,319						46
47	400 Wing - Chair Rail	2001	4,208						47
48	400 Wing - Door Guards	2001	607						48
49	400 Wing - Cubicle Tracks, Curtains, Window Treatments	2001	7,169						49
50	Fencing	2001	4,200						50
51	Storage Building	2001	3,268						51
52	Nurse Call System Upgrades	2001	3,700						52
53	Fire Alarm System Control Panel	2001	3,903						53
54	Replacement Signage	2001	3,656						54
55	Door Guards	2001	1,979						55
56	Overbed Lights	2001	1,625						56
57	Painting	2001	8,932						57
58	2P 50 AMP Discounect	2001	955						58
59	Mini Blinds	2001	14,744						59
60	Asphalts Paving of Parking Lot	2001	14,193						60
61	Air Conditioners	2001	3,424						61
62	Overbed Lights	2002	3,055						62
63	Cubicle curtains	2002	6,155						63
64	Air Conditioners	2002	1,398						64
65	Security Camera System	2002	1,010						65
66	Fire Doors	2002	1,543						66
67	Roofing - North Entrance	2002	1,680						67
68	Wall Guard & End Caps	2002	1,497						68
69	Door Canopy	2002	3,800						69
70	TOTAL (lines 4 thru 69)		$ 4,575,368	$		$	$	$	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Jerseyville Nsg & Rehab Ctr # 0053447 Report Period Beginning: 03/01/2015 Ending: 12/31/2015

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Jerseyville Nsg & Rehab Ctr # 0053447 Report Period Beginning: 03/01/2015 Ending: 12/31/2015

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Jerseyville Nsg & Rehab Ctr # 0053447 Report Period Beginning: 03/01/2015 Ending: 12/31/2015

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Jerseyville Nsg & Rehab Ctr # 0053447 Report Period Beginning: 03/01/2015 Ending: 12/31/2015

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 12D, Carried Forward		$ 5,506,154	$		$	$	$	1
2	3 A/C/Heat Units	2013	2,358						2
3	Oxygen Storage Facility	2013	1,124						3
4	Concrete Pad & Sidewalk	2013	2,250						4
5	Elecric Door Closer	2014	690						5
6	Painting	2014	400						6
7	Ceiling Tile	2014	1,066						7
8	A/C Units	2014	3,241						8
9	Door Alarm System	2014	25,765						9
10	Flooring-Labor Only	2014	992						10
11	Landscaping	2014	2,215						11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21	Related Party Allocation - Bridgemark:								21
22	New Office Build Out	2011	12,035		20	638	638	2,838	22
23	Conference Rm Chair Rail & Paint	2012	136		5	27	27	91	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,558,426	$		$ 665	$ 665	$ 2,929	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Jerseyville Nsg & Rehab Ctr # 0053447 Report Period Beginning: 03/01/2015 Ending: 12/31/2015

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	$ 11,657	$	$ 2,060	$ 2,060	4-15 yrs	$ 8,054	71
72	Current Year Purchases	11,966	1,055	1,089	34	4-15 yrs	1,089	72
73	Fully Depreciated Assets	2,955					2,955	73
74								74
75	TOTALS	$ 26,578	$ 1,055	$ 3,149	$ 2,094		$ 12,098	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77	Related Party Allocation - Bridgemark			1,177				4	1,177	77
78										78
79										79
80	TOTALS			$ 1,177	$	$	$		$ 1,177	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,657,845	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 1,055	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 3,814	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,759	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 16,204	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		$	$	$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Jerseyville Nsg & Rehab Ctr # 0053447 Report Period Beginning: 03/01/2015 Ending: 12/31/2015

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. [X] 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:		111		$ 556,468			3
4	Additions							4
5	Storage Rental				1,434			5
6	Related Party Allocation - Bridgemark				9,026			6
7	TOTAL		111		$ 566,928 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

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	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 25,734 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nsg & Rehab Ctr # 0053447 Report Period Beginning: 03/01/2015 Ending: 12/31/2015

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nsg & Rehab Ctr # 0053447 Report Period Beginning: 03/01/2015 Ending: 12/31/2015

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,2	hrs				17		17	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				239,985		239,985	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Wound, Oxy, Enterals	39,2					19,530		19,530	12
13	Other (specify): X-Ray, Labs, Therapy	39,8				448,769			448,769	13
14	TOTAL			$		$ 448,769	$ 259,532		$ 708,301	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 Jerseyville Nsg & Rehab Ctr # 0053447 Report Period Beginning: 03/01/2015 Ending: 12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2015 (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	$ (2,132)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 113,200)	1,124,462		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	7,983		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,130,313	$	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			15
16	Equipment, at Historical Cost	11,041		16
17	Accumulated Depreciation (book methods)	(1,055)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 9,986	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,140,299	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 224,582	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	132,097		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,119		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Assessment Tax	(1,633)		36
37	Due to Related Parties	428,314		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 795,479	$	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)**	$ 795,479	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 344,820	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,140,299	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Jerseyville Nsg & Rehab Ctr # 0053447 Report Period Beginning: 03/01/2015 Ending: 12/31/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$		1
2	Restatements (describe):			2
3				3
4				4
5				5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$		6
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)		344,820	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)**	$	344,820	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)**	$	344,820	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nsg & Rehab Ctr # 0053447 Report Period Beginning: 03/01/2015 Ending: 12/31/2015

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,756,619	1
2	Discounts and Allowances for all Levels	(113,200)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,643,419	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	155,265	6
7	Oxygen	1,047	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 156,312	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	1,215	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	155	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	60	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,430	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	113	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 113	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	2,163	28
28a	Flu Shots	2,575	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,738	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,806,012	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	883,692	31
32	Health Care	1,770,176	32
33	General Administration	1,052,531	33
	B. Capital Expense		
34	Ownership	666,586	34
	C. Ancillary Expense		
35	Special Cost Centers	920,059	35
36	Provider Participation Fee	168,148	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,461,192	40
41	**Income before Income Taxes (line 30 minus line 40)****	344,820	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 344,820	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,719,459	44
45	Private Pay - Net Inpatient Revenue	1,445,410	45
46	Medicare - Net Inpatient Revenue	2,180,578	46
47	Other-(specify) Insurance	266,097	47
48	Other-(specify) Hosice	31,874	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,643,419	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 Jerseyville Nsg & Rehab Ctr # 0053447 Report Period Beginning: 03/01/2015 Ending: 12/31/2015

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,650	1,787	$ 53,698	$ 30.05	1
2	Assistant Director of Nursing	1,716	1,812	49,430	27.28	2
3	Registered Nurses	11,603	12,228	284,165	23.24	3
4	Licensed Practical Nurses	12,767	13,538	286,725	21.18	4
5	CNAs & Orderlies	75,100	78,930	854,509	10.83	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,848	2,884	28,011	9.71	10
11	Social Service Workers	3,309	3,488	42,758	12.26	11
12	Dietician					12
13	Food Service Supervisor	1,894	1,950	24,335	12.48	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,388	20,152	178,670	8.87	15
16	Dishwashers					16
17	Maintenance Workers	2,661	2,729	38,403	14.07	17
18	Housekeepers	11,891	12,537	118,241	9.43	18
19	Laundry	5,179	5,454	48,389	8.87	19
20	Administrator	1,570	1,750	77,696	44.40	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,612	1,798	28,814	16.03	23
24	Clerical	3,412	3,587	46,080	12.85	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	1,597	1,747	21,687	12.41	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	158,197	166,371	$ 2,181,611 *	$ 13.11	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 6,214	1,3	35
36	Medical Director		15,010	9,3	36
37	Medical Records Consultant		937	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		6,467	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		3,665	11,3	44
45	Social Service Consultant		2,120	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 34,413		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

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

** See instructions.

Facility Name & ID Number Jerseyville Nsg & Rehab Ctr # 0053447 Report Period Beginning: 03/01/2015 Ending: 12/31/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Suzanne Bellm-Boston	Administrator	0	$ 77,696
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 77,696

B. Administrative - Other

Description	Amount
Bridgemark Healthcare L.L.C. - Management Fees	$ 300,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 300,000

C. Professional Services

Vendor/Payee	Type	Amount
Paycom Payroll, LLC	Payroll Processing	$ 11,323
Personnel Planners, Inc.	Unemployment Consulting	684
MidCap Funding I, LLC	Line of Credit amendment	1,003
Daniel Maher Law Office	Legal Fees	380
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 13,390

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 76,674
Unemployment Compensation Insurance	89,758
FICA Taxes	158,336
Employee Health Insurance	22,209
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Match	3,154
Employee Benefits	4,496
Other Employee Insurance	3,715
Related Party Allocation - Bridgemark	30,729
Related Party Allocation - NW Rehab	84,816
TOTAL (agree to Schedule V, line 22, col.8)	$ 473,887

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

Description	Line #	Amount
Section N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	90
Health Care Worker Background Check	2,018
(Indicate # of checks performed)	
Patient Background Checks	
Dues & Subscriptions	2,875
Late Fees	4,175
Miscellaneous Licenses & Fees	657
Advertising	16,746
Related Party Allocations	1,209
Less: Public Relations Expense	( )
Non-allowable advertising	(16,746)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,014

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	121
Seminar Expense	735
Related Party Allocation - Bridgemark	5,897
Related Party Allocation - NW Rehab	507
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,260

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nsg & Rehab Ctr # 0053447 Report Period Beginning: 03/01/2015 Ending: 12/31/2015

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	Amount of Expense Amortized Per Year								
					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 Jerseyville Nsg & Rehab Ctr # 0053447 Report Period Beginning: 03/01/2015 Ending: 12/31/2015

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 $2,437**

(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? **10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **12,854** 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. $ **168,148**
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? **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? **Yes** Indicate the amount. $ **1,215**

(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.

Helia Healthcare of Jerseyville
Attachment to Schedule XII B
Equipment Rentals
12/31/2015

	Description	
16A	Specialty Bed Rental	16,454
16B	Copier Lease	6,476
16C	Dietary Equipment	798
16D	Respiratory Equipment	1,275
16E	Related Party Allocation - Bridgemark Healthcare	731
		25,734