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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0053454

Facility Name: Montgomery Nrsg & Rehab Ctr

Address: South Rte 127 Box309 (Number) Hillsboro (City) 62049 (Zip Code)

County: Montgomery

Telephone Number: (217) 532-6126 **Fax #** (217) 532-9465

HFS ID Number:

Date of Initial License for Current Owners: 3/01/2015

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

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

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

Paid Preparer
(Signed) See Accountant's Preparation 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' PREPARATION REPORT

Facility Name & ID Number Montgomery Nrsg & Rehab Ctr # 0053454 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 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	110	Skilled (SNF)	110	40,260	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	40,260	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	22,477	10,487	4,476	37,440	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,477	10,487	4,476	37,440	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.00%

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 110 and days of care provided 3,402

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: 12/31/16 Fiscal Year: 12/31/16

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Montgomery Nrsg & Rehab Ctr # 0053454 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	250,149	14,209	8,276	272,634		272,634		272,634			1
2	Food Purchase		231,140		231,140		231,140	(321)	230,819			2
3	Housekeeping	125,310	30,686		155,996		155,996		155,996			3
4	Laundry	72,105	14,624		86,729		86,729		86,729			4
5	Heat and Other Utilities			141,805	141,805		141,805	(34,244)	107,561			5
6	Maintenance	62,369	11,460	56,924	130,753		130,753	18	130,771			6
7	Other (specify):*											7
8	TOTAL General Services	509,933	302,119	207,005	1,019,057		1,019,057	(34,547)	984,510			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	1,761,480	147,956	40,767	1,950,203		1,950,203	19,227	1,969,430			10
10a	Therapy		16		16		16		16			10a
11	Activities	70,612	4,142	6,172	80,926		80,926		80,926			11
12	Social Services	52,547		592	53,139		53,139		53,139			12
13	CNA Training					2,243	2,243		2,243			13
14	Program Transportation			5,452	5,452		5,452		5,452			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,884,639	152,114	62,583	2,099,336	2,243	2,101,579	19,227	2,120,806			16
	C. General Administration											
17	Administrative	102,877		332,700	435,577		435,577	(193,993)	241,584			17
18	Directors Fees											18
19	Professional Services			20,617	20,617		20,617	5,888	26,505			19
20	Dues, Fees, Subscriptions & Promotions			67,413	67,413		67,413	(48,847)	18,566			20
21	Clerical & General Office Expenses	87,522	23,202	84,396	195,120		195,120	207,041	402,161			21
22	Employee Benefits & Payroll Taxes			429,567	429,567		429,567	95,753	525,320			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,822	3,822	(2,243)	1,579	7,732	9,311			24
25	Other Admin. Staff Transportation			12,743	12,743		12,743	19,505	32,248			25
26	Insurance-Prop.Liab.Malpractice			75,934	75,934		75,934	1,436	77,370			26
27	Other (specify):*											27
28	TOTAL General Administration	190,399	23,202	1,027,192	1,240,793	(2,243)	1,238,550	94,515	1,333,065			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,584,971	477,435	1,296,780	4,359,186		4,359,186	79,195	4,438,381			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: 01/01/2016 Ending: 12/31/2016

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			4,984	4,984		4,984	2,424	7,408			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			23,933	23,933		23,933	4,035	27,968			32
33	Real Estate Taxes			54,589	54,589		54,589	27	54,616			33
34	Rent-Facility & Grounds			667,703	667,703		667,703	11,208	678,911			34
35	Rent-Equipment & Vehicles			56,160	56,160		56,160	1,111	57,271			35
36	Other (specify):*											36
37	TOTAL Ownership			807,369	807,369		807,369	18,805	826,174			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		149,463	628,810	778,273		778,273	(227,071)	551,202			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			269,101	269,101		269,101		269,101			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		149,463	897,911	1,047,374		1,047,374	(227,071)	820,303			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,584,971	626,898	3,002,060	6,213,929		6,213,929	(129,071)	6,084,858			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

Facility Name & ID Number Montgomery Nrsg & Rehab Ctr # 0053454 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(34,504)	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	(321)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(2,297)	21		19
20	Contributions	(730)	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	(39,633)	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	(10,264)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (87,749)		$	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)	(41,322)	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (41,322)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (129,071)		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Montgomery Nrsg & Rehab Ctr

ID# 0053454

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	To Eliminate Gifts and Flowers	$ (4,834)	20	1
2	To Eliminate Lobbying & PAC Dues	(3,440)	20	2
3	To Eliinate 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**	(10,264)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Montgomery Nrsg & Rehab Ctr # 0053454 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

	Operating Expenses	PAGES 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	(321)	0	0	0	0	0	0	0	0	0	0	(321)	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	(34,504)	260	0	0	0	0	0	0	0	0	0	(34,244)	5
6	Maintenance	0	0	18	0	0	0	0	0	0	0	0	18	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(34,825)	260	18	0	0	0	0	0	0	0	0	(34,547)	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	19,127	100	0	0	0	0	0	0	0	0	19,227	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	19,127	100	0	0	0	0	0	0	0	0	19,227	16
	C. General Administration													
17	Administrative	0	(296,128)	102,135	0	0	0	0	0	0	0	0	(193,993)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	5,888	0	0	0	0	0	0	0	0	0	5,888	19
20	Fees, Subscriptions & Promotions	(49,897)	838	212	0	0	0	0	0	0	0	0	(48,847)	20
21	Clerical & General Office Expenses	(3,027)	198,360	11,708	0	0	0	0	0	0	0	0	207,041	21
22	Employee Benefits & Payroll Taxes	0	30,251	65,502	0	0	0	0	0	0	0	0	95,753	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	7,013	719	0	0	0	0	0	0	0	0	7,732	24
25	Other Admin. Staff Transportation	0	9,001	10,504	0	0	0	0	0	0	0	0	19,505	25
26	Insurance-Prop.Liab.Malpractice	0	1,436	0	0	0	0	0	0	0	0	0	1,436	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(52,924)	(43,341)	190,780	0	0	0	0	0	0	0	0	94,515	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(87,749)	(23,954)	190,898	0	0	0	0	0	0	0	0	79,195	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Montgomery Nrsg & Rehab Ctr # 0053454 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	2,424	0	0	0	0	0	0	0	0	0	2,424	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	4,035	0	0	0	0	0	0	0	0	4,035	32
33	Real Estate Taxes	0	27	0	0	0	0	0	0	0	0	0	27	33
34	Rent-Facility & Grounds	0	11,208	0	0	0	0	0	0	0	0	0	11,208	34
35	Rent-Equipment & Vehicles	0	0	1,111	0	0	0	0	0	0	0	0	1,111	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	13,659	5,146	0	0	0	0	0	0	0	0	18,805	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	(227,071)	0	0	0	0	0	0	0	0	(227,071)	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	(227,071)	0	0	0	0	0	0	0	0	(227,071)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(87,749)	(10,295)	(31,027)	0	0	0	0	0	0	0	0	(129,071)	45

Facility Name & ID Number Montgomery Nrsg & Rehab Ctr # 0053454 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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.
		Helia Healthcare of Florissant	Florissant, MO	Bridgemark Emplyer Srvs	St. Louis, MO	Human Resources
		Helia Healthcare of Champaign	Champaign, IL	Bridgemark Medial Supply	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 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%	$ 260	$ 260	1
2	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	19,127	19,127	2
3	V	17	Management Fees	332,700	Bridgemark Healthcare, LLC	100.00%	36,572	(296,128)	3
4	V	19	Professional Services		Bridgemark Healthcare, LLC	100.00%	5,888	5,888	4
5	V	20	Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	838	838	5
6	V	21	Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	198,360	198,360	6
7	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	30,251	30,251	7
8	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	7,013	7,013	8
9	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	9,001	9,001	9
10	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	1,436	1,436	10
11	V	30	Deprciation		Bridgemark Healthcare, LLC	100.00%	2,424	2,424	11
12	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	27	27	12
13	V	34	Rent		Bridgemark Healthcare, LLC	100.00%	11,208	11,208	13
14	Total			$ 332,700			$ 322,405	$ * (10,295)	14

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

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%	$ 1,111	$ 1,111	15
16	V								16
17	V								17
18	V								18
19	V	6	Maintenance		NW Rehab, LLC	100.00%	18	18	19
20	V	10	Nursing & Med		NW Rehab, LLC	100.00%	100	100	20
21	V	39	Therapy		NW Rehab, LLC	100.00%	388,339	388,339	21
22	V	17	Admin Salaries		NW Rehab, LLC	100.00%	102,135	102,135	22
23	V	20	Dues & Subscriptions		NW Rehab, LLC	100.00%	212	212	23
24	V	21	Clerical & Office		NW Rehab, LLC	100.00%	11,708	11,708	24
25	V	22	Employee Benefits & Payroll Taxes		NW Rehab, LLC	100.00%	65,502	65,502	25
26	V	24	Travel & Seminar		NW Rehab, LLC	100.00%	719	719	26
27	V	25	Other Admin Transportation		NW Rehab, LLC	100.00%	10,504	10,504	27
28	V	32	Interest		NW Rehab, LLC	100.00%	4,035	4,035	28
29	V	39	Ancillary Service Centers	615,410	NW Rehab, LLC	100.00%		(615,410)	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			$ 615,410			$ 584,383	$ * (31,027)	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: 01/01/2016 Ending: 12/31/2016

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			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' PREPARATION REPORT

Facility Name & ID Number Montgomery Nrsg & Rehab Ctr # 0053454 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	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	324,971	5.06	10.12	Distribution	$ 36,572	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	$ 36,572		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 Nrsg & Rehab Ctr # 0053454 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	370,125	13	$ 2,569	$	37,440	$ 260	1
2	10	Nursing & Medical Records	Resident Days	370,125	13	189,088	189,088	37,440	19,127	2
3	17	Owners Compensation	Resident Days	370,125	13	361,543		37,440	36,572	3
4	19	Professional Fees	Resident Days	370,125	13	58,207		37,440	5,888	4
5	20	Dues, Subscriptions	Resident Days	370,125	13	8,280		37,440	838	5
6	21	Salaries - Other	Resident Days	370,125	13	1,575,742	1,575,742	37,440	159,394	6
7	21	Clerical & Office Supplies	Resident Days	370,125	13	385,214		37,440	38,966	7
8	22	Emp. Benefits & Payroll Taxes	Resident Days	370,125	13	299,056		37,440	30,251	8
9	24	Seminars	Resident Days	370,125	13	69,325		37,440	7,013	9
10	25	Admin Staff Travel	Resident Days	370,125	13	88,978		37,440	9,001	10
11	26	Insurance	Resident Days	370,125	13	14,200		37,440	1,436	11
12	30	Depriciation	Resident Days	370,125	13	23,966		37,440	2,424	12
13	33	Real Estate Taxes	Resident Days	370,125	13	267		37,440	27	13
14	34	Building Rent	Resident Days	370,125	13	102,424		37,440	10,361	14
15	34	Rental - Stoarge Unit	Resident Days	370,125	13	8,376		37,440	847	15
16	35	Equipment Rental	Resident Days	370,125	13	10,984		37,440	1,111	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,198,219	$ 1,764,830		$ 323,516	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Montgomery Nrsg & Rehab Ctr # 0053454 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: NW 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	2,513,226	14	$ 75	$	615,410	$ 18	1
2	10	Nursing & Med	Revenue	2,513,226	14	407		615,410	100	2
3	39	Therapy	Revenue	2,513,226	14	1,585,909	1,585,909	615,410	388,339	3
4	17	Admin Salaries	Revenue	2,513,226	14	417,103	417,103	615,410	102,135	4
5	20	Dues & Subscriptions	Revenue	2,513,226	14	864		615,410	212	5
6	21	Salaries - Other	Revenue	2,513,226	14			615,410		6
7	21	Clerical & Ofice Supplies	Revenue	2,513,226	14	47,814		615,410	11,708	7
8	22	Employee Benefits	Revenue	2,513,226	14	267,498		615,410	65,502	8
9	24	Travel & Seminar	Revenue	2,513,226	14	2,935		615,410	719	9
10	25	Other Admin Transportation	Revenue	2,513,226	14	42,896		615,410	10,504	10
11	32	Interest	Revenue	2,513,226	14	16,479		615,410	4,035	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,381,980	$ 2,003,012		$ 583,272	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Montgomery Nrsg & Rehab Ctr # 0053454 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MidCap Funding I, LLC		X	Line of Credit		10/22/09				Variable	23,933	6
7	Related Party Allocation										4,035	7
8												8
9	TOTAL Facility Related						$	$			$ 27,968	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 27,968	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Montgomery Nrsg & Rehab Ctr # 0053454 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	51,469	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.)	$	54,589	2
3. Under or (over) accrual (line 2 minus line 1).	$	3,120	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$	51,469	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.	$	54,589	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2011	49,906	8
2012	49,510	9
2013	52,025	10
2014	55,230	11
2015	54,589	12

54,589 Line 7, Real Estate Tax portion of Lease payments
27 Bridgemark Healthcare Allocation
54,616 Total Schedule V, Line 33

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

SEE ACCOUNTANTS' PREPARATION REPORT

2015 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 Jason Mills

TELEPHONE (314) 317-2003 FAX #: (314) 754-9176

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-13-379-001	NE PT SE SW Land Corp Limit	$ 54,588.90	$ 54,588.90
2.		Taylor Springs 8-4-716 3/4 S13	$	$
3.		T08 R4	$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 54,588.90	$ 54,588.90

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number Montgomery Nrsg & Rehab Ctr # 0053454 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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. [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).

None

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility -Prior Owner	348,480	1994	$ 27,673	1
2					2
3	TOTALS	348,480		$ 27,673	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Montgomery Nrsg & Rehab Ctr # 0053454 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

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

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Montgomery Nrsg & Rehab Ctr # 0053454 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Fire Doors	2002	$ 1,042	$		$	$	$	37
38	AC/Heat Pumps	2002	1,580						38
39	Air Conditioning Unit	2003	3,110						39
40	11 Fire Doors	2003	5,950						40
41	Closet Door - Resident Rooms	2004	3,628						41
42	Wiring Outside Lightts	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 Doors - Resident Rooms	2005	3,689						50
51	Ouside Light Fixtures	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	Exhaust 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: 01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 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 Conditiong Units	2007	3,512						6
7	Flooring	2007	10,399						7
8	Landscaping - Sign Area	2007	2,575						8
9	Repaved 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	New 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: 01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 1,866,023	$		$	$	$	1
2	Insulate Duct Work	2010	14,800						2
3	Kithcen 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 Heater	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	Secrity 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	Nuse Call System Upgrade	2013	7,082						22
23	Electical Work - 2 New Circuits	2013	1,615						23
24	5 New Vinyl Doors	2013	765						24
25	Hot Water Heater (10 Gal.) & Mising Valve	2013	2,239						25
26	5 Ton 13 Seer Rooftoop A/C Unit	2013	6,071						26
27	400 & 500 Hall 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.

Facility Name & ID Number Montgomery Nrsg & Rehab Ctr # 0053454 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1 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 Doors	2014	2,781						2
3	Shower room walls - demo, frame, and drywall	2014	2,267						3
4	Flooring for kitchen and dining room	2014	6,450						4
5	Plumbing - New mixing valves and thermostat	2014	3,422						5
6	Wallpaper for dining room	2014	2,165						6
7	Landscaping	2014	2,360						7
8									8
9									9
10	Heating/Cooling System	2015	6,799	1,360	5	1,360		1,813	10
11									11
12									12
13									13
14	Related Party Allocation - Bridgemark:								14
15	New Office Build-Out	2011	13,738		20	728	728	3,967	15
16	Conference Rm Chair Rail & Paint	2012	155		5	31	31	135	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	TOTAL (lines 1 thru 33)		$ 2,224,297	$ 1,360		$ 2,119	$ 759	$ 5,915	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: 01/01/2016 Ending: 12/31/2016

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	$ 21,656	$ 2,591	$ 4,215	$ 1,624	3-15	$ 8,416	71
72	Current Year Purchases	14,642	1,033	1,074	41	3-15	1,074	72
73	Fully Depreciated Assets	8,709					8,709	73
74								74
75	TOTALS	$ 45,007	$ 3,624	$ 5,289	$ 1,665		$ 18,199	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			1,344				4	1,344	77
78										78
79										79
80	TOTALS			$ 1,344	$	$	$		$ 1,344	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)	$ 2,298,321	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 4,984	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 7,408	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,424	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 25,458	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

Facility Name & ID Number Montgomery Nrsg & Rehab Ctr # 0053454 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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:		110		$ 665,531			3
4	Additions							4
5	Storage Rental				2,172			5
6	Related Party Allocation - Bridgemark				11,208			6
7	TOTAL		110		$ 678,911 **			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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 57,271 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Montgomery Nrsg & Rehab Ctr # 0053454 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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? [X] YES [ ] NO

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

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA 80

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER CNA 40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		1,138		1,138
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments		585		585
8	CNA Competency Tests		520		520
9	TOTALS	$	$ 2,243	$	$ 2,243
10	SUM OF line 9, col. 1 and 2 (e)	$ 2,243			

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	8
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	8

(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

Facility Name & ID Number Montgomery Nrsg & Rehab Ctr # 0053454 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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				16		16	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				131,944		131,944	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Wound, Oxy, Enterals	39,2					17,519		17,519	12
13	Other (specify): X-Ray, Labs, Therapy	39,8				401,739			401,739	13
14	TOTAL			$		$ 401,739	$ 149,479		$ 551,218	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

Facility Name & ID Number Montgomery Nrsg & Rehab Ctr # 0053454 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2016 (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	$ 7,684	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 126,426)	1,695,805		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	54,182		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Deposits	165,436		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,923,107	$	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	6,799		15
16	Equipment, at Historical Cost	26,186		16
17	Accumulated Depreciation (book methods)	(5,740)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	52,407		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 79,652	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,002,759	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 279,721	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	182,784		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,545		31
32	Accrued Real Estate Taxes(Sch.IX-B)	51,469		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	32,160		36
37	Due to Related Parties	1,272,035		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,830,714	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,830,714	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 172,045	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,002,759	$	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name & ID Number Montgomery Nrsg & Rehab Ctr # 0053454 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (242,614)	1
2	Restatements (describe):		2
3	**Prior Year Adjustments after Cost Report was Issued**	46,893	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (195,721)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	367,766	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)**	$ 367,766	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)**	$ 172,045	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Montgomery Nrsg & Rehab Ctr # 0053454 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,311,360	1
2	Discounts and Allowances for all Levels	(108,300)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,203,060	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	378,260	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 378,260	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	60	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 60	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	315	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 315	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,581,695	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,019,057	31
32	Health Care	2,099,336	32
33	General Administration	1,240,793	33
	B. Capital Expense		
34	Ownership	807,369	34
	C. Ancillary Expense		
35	Special Cost Centers	778,273	35
36	Provider Participation Fee	269,101	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,213,929	40
41	**Income before Income Taxes (line 30 minus line 40)****	367,766	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 367,766	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,885,569	44
45	Private Pay - Net Inpatient Revenue	1,529,220	45
46	Medicare - Net Inpatient Revenue	1,519,051	46
47	Other-(specify) Insurance	215,699	47
48	Other-(specify) Hospice	53,521	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,203,060	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: 01/01/2016 Ending: 12/31/2016

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	1,898	2,109	$ 73,555	$ 34.88	1
2	Assistant Director of Nursing	1,810	2,085	59,448	28.51	2
3	Registered Nurses	4,713	5,168	146,473	28.34	3
4	Licensed Practical Nurses	22,168	24,171	467,396	19.34	4
5	CNAs & Orderlies	83,023	88,134	986,819	11.20	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,681	6,004	70,612	11.76	10
11	Social Service Workers	1,869	2,086	52,547	25.19	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,730	21,467	250,149	11.65	15
16	Dishwashers					16
17	Maintenance Workers	3,376	3,885	62,369	16.05	17
18	Housekeepers	11,026	11,661	125,310	10.75	18
19	Laundry	6,874	7,435	72,105	9.70	19
20	Administrator	1,925	2,130	102,877	48.30	20
21	Assistant Administrator					21
22	Other Administrative	1,921	2,126	25,836	12.15	22
23	Office Manager	2,105	2,345	61,686	26.31	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	1,967	2,219	27,789	12.52	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	170,086	183,025	$ 2,584,971 *	$ 14.12	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

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		$ 8,276	1,3	35
36	Medical Director		9,600	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		13,049	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		6,172	11,3	44
45	Social Service Consultant		592	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 37,689		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

Facility Name & ID Number Montgomery Nrsg & Rehab Ctr # 0053454 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Carla Vonder Haar	Adminstrator	0	$ 102,877
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 102,877

B. Administrative - Other

Description	Amount
Bridgemark Healthcare L.L.C. - Management Fees	$ 332,700
TOTAL (agree to Schedule V, line 17, col. 3)	$ 332,700
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Paycom Payroll, LLC	Payroll Processing	$ 15,263
C.J. Schlosser & Company, LLC	Accounting Services	3,775
Personnel Planners, Inc.	Unemployment Consulting	1,382
Ashman and Stein	Legal Fees	197
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 20,617

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 116,080
Unemployment Compensation Insurance	73,686
FICA Taxes	192,974
Employee Health Insurance	37,554
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Match	6,117
Employee Benefits	1,510
Other Employee Insurance	1,646
Related Party Allocation - Bridgemark	30,251
Related Party Allocation - NW Rehab	65,502
TOTAL (agree to Schedule V, line 22, col.8)	$ 525,320

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

Description	Line #	Amount
Section N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	2,622
Health Care Worker Background Check	1,516
(Indicate # of checks performed)	
Patient Background Checks	
Dues & Subscriptions	5,312
Late Fees	5,661
Miscellaneous Licenses & Fees	415
Advertising	39,633
Related Party Allocations	1,050
Less: Public Relations Expense	( )
Non-allowable advertising	(39,633)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,566

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,579
Related Party Allocation - Bridgemark	7,013
Related Party Allocation - NW Rehab	719
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,311

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Montgomery Nrsg & Rehab Ctr # 0053454 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 $4,392**

(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. $ **28,295** 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. $ **269,101**
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' PREPARATION 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? **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

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

	Description	
16A	Specialty Bed Rental	44,038
16B	Respiratory Equipment	3,146
16C	Copier Lease	6,785
16D	Related Party Allocation - Bridgemark Healthcare	1,111
16E	Dietary Equipment	2,191
		57,271

Helia Healthcare of Hillsboro
12/31/16

Account ID	Account Description	Date	Reference	Jrnl	Job Description	Trans Description	Debit Amt
90652	Travel: Mileage/Fuel	1/5/16	010516	PJ		Dollar General - doll for resident	10.63
90652	Travel: Mileage/Fuel	1/7/16	I-0063933	PJ		FKG Oil - Fuel charges 1/16	368.38
90652	Travel: Mileage/Fuel	1/15/16	011516	PJ	Office Assistant	Ginny Turner - mileage	87.05
90652	Travel: Mileage/Fuel	1/18/16	CVH: 2016-01-18	CDJ	Administrator	Carla Vonder-Haar - Auto Mileage	11.88
90652	Travel: Mileage/Fuel	1/18/16	CVH: 2016-01-18	CDJ	Administrator	Carla Vonder Haar - Auto Mileage	11.88
90652	Travel: Mileage/Fuel	2/1/16	020116	PJ	Office Assistant	Ginny Turner	71.87
90652	Travel: Mileage/Fuel	2/7/16	110244 2/16	PJ		FKG Oil - Fuel charges 2/16	470.39
90652	Travel: Mileage/Fuel	2/26/16	022616	PJ	Office Assistant	Ginny Turner - mileage	183.01
90652	Travel: Mileage/Fuel	2/29/16	CVH: 2016-02-29	CDJ	Administrator	Carla Vonder-Haar - Auto Mileage	192.24
90652	Travel: Mileage/Fuel	3/7/16	I-0064665	PJ		FKG Oil - Fuel charges 2/8/16-3/07/16	356.06
90652	Travel: Mileage/Fuel	3/11/16	031116	PJ	Director of Social Services	Tammy Richmond	43.20
90652	Travel: Mileage/Fuel	3/17/16	031716	PJ	Director of Nursing	Amy Maedge	62.64
90652	Travel: Mileage/Fuel	3/18/16	031816	PJ		Casey's - cigs for resident	68.20
90652	Travel: Mileage/Fuel	3/22/16	032216	PJ	Office Assistant	Ginny Turner - mileage	288.09
90652	Travel: Mileage/Fuel	3/31/16	033116	PJ	Activity Team Member	Alicia Aumiller	14.58
90652	Travel: Mileage/Fuel	3/31/16	033116	PJ	Director of Activities	Mandy Smith	22.68
90652	Travel: Mileage/Fuel	4/1/16	CV: 2016-03-21	CDJ	Administrator	Carla Vonder-Haar - Auto Mileage	78.30
90652	Travel: Mileage/Fuel	4/7/16	I-0064999	PJ		FKG Oil - Fuel charges 03/09/15-4/06/16	412.11
90652	Travel: Mileage/Fuel	5/1/16	040816	PJ	Office Assistant	Ginny Turner	118.53
90652	Travel: Mileage/Fuel	5/1/16	041816	PJ	Office Assistant	Jennifer Twitty	73.98
90652	Travel: Mileage/Fuel	5/1/16	042016	PJ	Director of Nursing	Amy Maedge	30.78
90652	Travel: Mileage/Fuel	5/1/16	042116	PJ	Office Assistant	Ginny Turner	103.68
90652	Travel: Mileage/Fuel	5/1/16	042816	PJ	Director of Social Services	Tammy Richmond	60.48
90652	Travel: Mileage/Fuel	5/2/16	050216	PJ	Director of Nursing	Amy Maedge	27.00
90652	Travel: Mileage/Fuel	5/2/16	CVH: 2016-05-02	CDJ	Administrator	Carla Vonder-Haar - Auto Mileage	70.74
90652	Travel: Mileage/Fuel	5/7/16	I-0065338	PJ		FKG Oil - Fuel charges 04/09/15-5/06/16	697.09
90652	Travel: Mileage/Fuel	5/16/16	CVH: 2016-05-16	CDJ	Administrator	Carla Vonder-Haar - Auto Mileage	43.74
90652	Travel: Mileage/Fuel	5/23/16	052316	PJ	Office Assistant	Ginny Turner	113.45
90652	Travel: Mileage/Fuel	5/30/16	CVH: 2016-05-30	CDJ	Administrator	Carla Vonder-Haar - Auto Mileage	117.18
90652	Travel: Mileage/Fuel	6/7/16	I-0065677	PJ		FKG Oil - Fuel charges 05/09/15-6/06/16	555.56
90652	Travel: Mileage/Fuel	6/13/16	CVH: 2016-06-13	CDJ	Administrator	Carla Vonder-Haar - Auto Mileage	36.18
90652	Travel: Mileage/Fuel	6/27/16	CVH: 2016-06-27	CDJ	Administrator	Carla Vonder-Haar - Auto Mileage	165.78
90652	Travel: Mileage/Fuel	7/7/16	I-0066025	PJ		FKG Oil - Fuel charges 06/09/15-7/06/16	679.30
90652	Travel: Mileage/Fuel	8/1/16	CVH: 2016-07-11	CDJ	Administrator	Carla Vonder-Haar - Auto Mileage	20.52
90652	Travel: Mileage/Fuel	8/7/16	I-0066367	PJ		FKG Oil - Fuel charges 07/09/15-8/06/16	747.54
90652	Travel: Mileage/Fuel	8/11/16	CVH: 2016-08-11	CDJ	Administrator	Carla Vonder Haar - Auto Mileage	20.52
90652	Travel: Mileage/Fuel	8/24/16	082416	PJ	Office Assistant	Ginny Turner - mileage	117.56
90652	Travel: Mileage/Fuel	8/26/16	082616	PJ	Director of Nursing	Amy Maedge - mileage	71.28
90652	Travel: Mileage/Fuel	8/30/16	083016	PJ	Director of Social Services	Tammy Richmond - mileage	59.94
90652	Travel: Mileage/Fuel	9/7/16	I-0066709	PJ		FKG Oil - Fuel charges 08/10/15-9/07/16	740.14
90652	Travel: Mileage/Fuel	10/1/16	CVH: 2016-08-20	CDJ	Administrator	Carla Vonder-Haar - Auto Mileage	239.22
90652	Travel: Mileage/Fuel	10/1/16	CVH: 2016-09-19	CDJ	Administrator	Carla Vonder-Haar - Auto Mileage	204.12
90652	Travel: Mileage/Fuel	10/7/16	I-0067087	PJ		FKG Oil - Fuel charges 09/10/15-10/06/16	577.17
90652	Travel: Mileage/Fuel	10/18/16	CVH: 2016-10-18	CDJ	Administrator	Carla Vonder-Haar - Auto Mileage	286.20
90652	Travel: Mileage/Fuel	10/24/16	1748	CDJ		MotoMart - Travel: Mileage/Fuel	46.28
90652	Travel: Mileage/Fuel	10/24/16	1749	CDJ		MotoMart - Travel: Mileage/Fuel	31.00
90652	Travel: Mileage/Fuel	10/26/16	1751	CDJ		MotoMart - Travel: Mileage/Fuel	31.00
90652	Travel: Mileage/Fuel	10/26/16	1752	CDJ	Director of Social Services	Tammy Richmond - Travel: Mileage/Fuel	62.10
90652	Travel: Mileage/Fuel	11/7/16	I-0067387	PJ		FKG Oil - Fuel charges 10/10/15-11/06/16	381.20
90652	Travel: Mileage/Fuel	11/28/16	CVH: 2016-11-28	CDJ	Administrator	Carla Vonder-Haar - Auto Mileage	343.44
90652	Travel: Mileage/Fuel	12/7/16	I-0067722	PJ		FKG Oil - Fuel charges 11/08/15-12/07/16	589.94
90652	Travel: Mileage/Fuel	12/19/16	121916	PJ	Office Assistant	Ginny Turner - mileage	80.46
90652	Travel: Mileage/Fuel	12/20/16	122016	PJ	Director of Social Services	Tammy Richmond - mileage	34.56
90651	Travel: Vehicle Repairs/Tires						2,411.67
							12,742.52

HELIA HEALTHCARE OF HILLSBORO
RECLASSIFICATIONS
MEDICAID COST REPORT
12/31/16

	AMOUNT	LN #
A		
TRAVEL AND SEMINAR	(2,243)	24
C.N.A. TRAINING	2,243	13
TO RECLASS C.N.A. TRAINING		