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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0053447

Facility Name: Helia Healthcare of Jerseyville d/b/a Jerseyville Nursing & Rehabilitation Center

Address: 1001 South State Street (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: 03/01/15

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 01/01/17 to 12/31/17 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) Chief Financial Officer

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 Helia Healthcare of Jerseyville d/b/a Jerseyville Nursing & Rehabilitation Center # 0053447 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	40,515	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	40,515	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	15,447	9,834	6,460	31,741	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,447	9,834	6,460	31,741	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.34%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 4,970

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: 12/31/17 Fiscal Year: 12/31/17

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Jerseyville d/b/a Jerseyvil # 0053447 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	213,060	18,116	6,742	237,918		237,918		237,918			1
2	Food Purchase		236,577		236,577		236,577	(363)	236,214			2
3	Housekeeping	123,693	28,865	175	152,733		152,733		152,733			3
4	Laundry	53,866	16,252		70,118		70,118		70,118			4
5	Heat and Other Utilities			165,566	165,566		165,566	(6,453)	159,113			5
6	Maintenance	59,992	15,105	56,708	131,805		131,805		131,805			6
7	Other (specify):*											7
8	TOTAL General Services	450,611	314,915	229,191	994,717		994,717	(6,816)	987,901			8
	B. Health Care and Programs											
9	Medical Director			18,012	18,012		18,012		18,012			9
10	Nursing and Medical Records	1,813,974	103,969	100,116	2,018,059		2,018,059	28,776	2,046,835			10
10a	Therapy	13,517	409		13,926		13,926		13,926			10a
11	Activities	58,873	2,673	3,263	64,809		64,809	(24)	64,785			11
12	Social Services	25,223	107	1,702	27,032		27,032		27,032			12
13	CNA Training											13
14	Program Transportation			86	86		86		86			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,911,587	107,158	123,179	2,141,924		2,141,924	28,752	2,170,676			16
	C. General Administration											
17	Administrative	105,404		335,000	440,404		440,404	(154,451)	285,953			17
18	Directors Fees											18
19	Professional Services			25,247	25,247		25,247	19,448	44,695			19
20	Dues, Fees, Subscriptions & Promotions			156,283	156,283		156,283	(22,293)	133,990			20
21	Clerical & General Office Expenses	99,252	22,810	185,526	307,588		307,588	111,417	419,005			21
22	Employee Benefits & Payroll Taxes			359,955	359,955		359,955	102,802	462,757			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,244	2,244		2,244	12,385	14,629			24
25	Other Admin. Staff Transportation			4,840	4,840		4,840	20,864	25,704			25
26	Insurance-Prop.Liab.Malpractice			123,787	123,787		123,787	3,295	127,082			26
27	Other (specify):*											27
28	TOTAL General Administration	204,656	22,810	1,192,882	1,420,348		1,420,348	93,467	1,513,815			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,566,854	444,883	1,545,252	4,556,989		4,556,989	115,403	4,672,392			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: Helia Healthcare of Jerseyville d/b/a Jerseyville Nursing & R #0053447 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			6,756	6,756		6,756	1,832	8,588			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,759	5,759		5,759	6,165	11,924			32
33	Real Estate Taxes			93,434	93,434		93,434	24	93,458			33
34	Rent-Facility & Grounds			683,641	683,641		683,641	8,674	692,315			34
35	Rent-Equipment & Vehicles			32,145	32,145		32,145	815	32,960			35
36	Other (specify):*											36
37	**TOTAL Ownership**			821,735	821,735		821,735	17,510	839,245			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		183,515	739,402	922,917		922,917	(263,439)	659,478			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			221,984	221,984		221,984		221,984			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		183,515	961,386	1,144,901		1,144,901	(263,439)	881,462			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,566,854	628,398	3,328,373	6,523,625		6,523,625	(130,526)	6,393,099			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 Helia Healthcare of Jerseyville d/b/a Jerseyville Nursing & # 0053447 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	(24)	11		4
5	Telephone, TV & Radio in Resident Rooms	(6,729)	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	(363)	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	(66,931)	21		18
19	Entertainment	(208)	21		19
20	Contributions	(25)	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	(18,198)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(4,872)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (97,575)		$	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)	(32,951)	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (32,951)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (130,526)		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

Helia Healthcare of Jerseyville d/b/a Jerseyville Nursing & Rehabilitation Center

ID# 0053447

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	To Eliminate Gifts and Flowers	$ (2,227)	20	1
2	To Eliminate Lobbying & PAC Dues	(2,645)	20	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
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33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(4,872)		49

Facility Name & ID Number Helia Healthcare of Jerseyville d/b/a Jerseyville Nursing & Rehabilitation Cent # 0053447 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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%	$ 276	$ 276	1
2	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	28,756	28,756	2
3	V	17	Management Fees	335,000	Bridgemark Healthcare, LLC	100.00%	68,192	(266,808)	3
4	V	19	Professional Services		Bridgemark Healthcare, LLC	100.00%	19,448	19,448	4
5	V	20	Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	965	965	5
6	V	21	Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	170,317	170,317	6
7	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	24,585	24,585	7
8	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	7,941	7,941	8
9	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	8,148	8,148	9
10	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	2,345	2,345	10
11	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	1,832	1,832	11
12	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	24	24	12
13	V	34	Rent		Bridgemark Healthcare, LLC	100.00%	8,674	8,674	13
14	Total			$ 335,000			$ 341,503	$ * 6,503	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Jerseyville d/b/a Jerseyville Nursing & Rehabilitation Center # 0053447 Report Period Beginning: 01/01/17 Ending: 12/31/17

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%	$ 815	$ 815	15
16	V								16
17	V								17
18	V								18
19	V	10	Nursing & Med		NW Rehab, LLC	100.00%	20	20	19
20	V	39	Ancillary Service Centers	700,570	NW Rehab, LLC	100.00%	437,131	(263,439)	20
21	V	17	Administration		NW Rehab, LLC	100.00%	112,357	112,357	21
22	V	20	Dues & Subscriptions		NW Rehab, LLC	100.00%	37	37	22
23	V	21	Clercial & Office		NW Rehab, LLC	100.00%	8,264	8,264	23
24	V	22	Employee Benefits		NW Rehab, LLC	100.00%	78,217	78,217	24
25	V	24	Travel & Seminar		NW Rehab, LLC	100.00%	4,444	4,444	25
26	V	25	Other Admin Transp		NW Rehab, LLC	100.00%	12,716	12,716	26
27	V	26	Insurance - Prop Liab, Malprac		NW Rehab, LLC	100.00%	950	950	27
28	V	32	Interest		NW Rehab, LLC	100.00%	6,165	6,165	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			$ 700,570			$ 661,116	$ * (39,454)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Jerseyville d/b/a Jerseyville Nursing & Rehabilitati # 0053447 Report Period Beginning: 01/01/17 Ending: 12/31/17

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
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14								14
15								15
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24								24
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26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Jerseyville d/b/a Jerseyv # 0053447 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	708,596	4.39	8.78	Distribution	$ 68,192	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	$ 68,192		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 Helia Healthcare of Jerseyville d/b/a Jerseyville Nursing & # 0053447 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	361,568	13	$ 3,142	$	31,741	$ 276	1
2	10	Nursing & Medical Supplies	Resident Days	361,568	13	327,569	327,569	31,741	28,756	2
3	17	Owner's Compensation	Resident Days	361,568	13	776,788		31,741	68,192	3
4	19	Professional Fees	Resident Days	361,568	13	221,539		31,741	19,448	4
5	20	Dues, Subscriptions	Resident Days	361,568	13	10,991		31,741	965	5
6	21	Salaries - Other	Resident Days	361,568	13	1,561,133	1,561,133	31,741	137,047	6
7	21	Clercial & Office Supplies	Resident Days	361,568	13	378,981		31,741	33,270	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	361,568	13	280,058		31,741	24,585	8
9	24	Seminars	Resident Days	361,568	13	90,455		31,741	7,941	9
10	25	Admin Staff Travel	Resident Days	361,568	13	92,816		31,741	8,148	10
11	26	Insurance	Resident Days	361,568	13	26,711		31,741	2,345	11
12	30	Depreciation	Resident Days	361,568	13	20,874		31,741	1,832	12
13	33	Real Estate Taxes	Resident Days	361,568	13	269		31,741	24	13
14	34	Building Rent	Resident Days	361,568	13	95,732		31,741	8,404	14
15	34	Rental - Storage Unit	Resident Days	361,568	13	3,073		31,741	270	15
16	35	Equipment Rental	Resident Days	361,568	13	9,286		31,741	815	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,899,417	$ 1,888,702		$ 342,318	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Jerseyville d/b/a Jerseyville Nursing & # 0053447 Report Period Beginning: 01/01/17 Ending: 12/31/17

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						$	$		$	1
2	10	Nursing & Med	Revenue	2,581,783	19	73		700,570	20	2
3	39	Therapy	Revenue	2,581,783	19	1,610,941	1,610,941	700,570	437,131	3
4	17	Admin Salaries	Revenue	2,581,783	19	414,064	414,064	700,570	112,357	4
5	20	Dues & Subscriptions	Revenue	2,581,783	19	136		700,570	37	5
6										6
7	21	Clerical & Office Supplies	Revenue	2,581,783	19	30,456		700,570	8,264	7
8	22	Employee Benefits	Revenue	2,581,783	19	288,251		700,570	78,217	8
9	24	Travel & Seminar	Revenue	2,581,783	19	16,377		700,570	4,444	9
10	25	Other Admin Transp	Revenue	2,581,783	19	46,860		700,570	12,716	10
11	26	Insurance - Prop Liab, Malprac	Revenue	2,581,783	19	3,500		700,570	950	11
12	32	Interest	Revenue	2,581,783	19	22,721		700,570	6,165	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,433,379	$ 2,025,005		$ 660,301	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Jerseyville d/b/a Jerseyvi # 0053447 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	Line of Credit		10/22/09				Variable	5,759	6
7	Related Party Allocations - NW Rehab										6,165	7
8												8
9	TOTAL Facility Related						$	$			$ 11,924	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 11,924	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 Helia Healthcare of Jerseyville d/b/a Jerseyville Nursing & Rehabilitation # 0053447 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 78,927	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.)		$ 86,180	2
3. Under or (over) accrual (line 2 minus line 1).		$ 7,253	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 86,181	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.		$ 93,434	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	76,650	8
	2013	78,413	9
	2014	83,157	10
	2015	85,927	11
	2016	86,180	12

93,434	Line 7, Portion of Lease Payments allocated to Real Estate Taxes
24	Related Party Allocation -- Bridgemark
93,458	Total Schedule V, Line 33

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Helia Healthcare of Jerseyville d/b/a Jerseyville Nursing & R COUNTY Jersey

FACILITY IDPH LICENSE NUMBER 0053447

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 2016 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2016.

	(A) 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	$ 81,450.08	$ 81,450.08
2.		Outlot 6	$	$
3.	04-208-017-00	S 28 T8 R11 Unplatted Parcels	$ 4,730.00	$ 4,730.00
4.		S&W PT SE 1/4 NE 1/4 Less E PT	$	$
5.		Less .10 ACS for HWY	$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 86,180.08	$ 86,180.08

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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

Facility Name & ID Number Helia Healthcare of Jerseyville d/b/a Jerseyville Nursing & Rehabilitation Cente # 0053447 Report Period Beginning: 01/01/17 Ending: 12/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,823 B. General Construction Type: Exterior Brick and 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).

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: 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 - Prior Owner	158,994	1994	$ 71,664	1
2					2
3	TOTALS	158,994		$ 71,664	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Jerseyville d/b/a Jerseyville Nursing & Rehabilitation C # 0053447 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Remodeling			1994	10,000						10
11	Elecyrical			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.

See Page 12A, Line 70 for total

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Jerseyville d/b/a Jerseyville Nursing & Rehabilitation C# 0053447 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	Const. 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 Station	2001	10,104						40
41	400 Wing - Cable TV Sytem 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 & Wall Guards	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 Upgrade	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 Discount	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' PREPARATION REPORT

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

Facility Name & ID Number Helia Healthcare of Jerseyville d/b/a Jerseyville Nursing & Rehabilitation C# 0053447 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Detector	2004	1,600						7
8	Extend Activities Wall/Replace Doors	2004	2,002						8
9	Air Conditions	2004	1,814						9
10	Cove Base	2004	2,188						10
11	Hollow Metal 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 Awning - 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 Tile	2006	4,411						32
33	Sprinkler Sytem Improvements	2006	5,025						33
34	TOTAL (lines 1 thru 33)		$ 4,795,240	$		$	$	$	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Helia Healthcare of Jerseyville d/b/a Jerseyville Nursing & Rehabilitation C# 0053447 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	Coincrete 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 Pavillion 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' PREPARATION REPORT

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

Facility Name & ID Number Helia Healthcare of Jerseyville d/b/a Jerseyville Nursing & Rehabilitation C # 0053447 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Storage	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 Nurses 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 Elecrical	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 Heater & 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 Units	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' PREPARATION REPORT

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

Facility Name & ID Number Helia Healthcare of Jerseyville d/b/a Jerseyville Nursing & Rehabilitation C# 0053447 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	Concete Pad & Sidewalk	2013	2,250						4
5	Electric 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	Stage 1 Compressor Replacement	2016	4,652	388	12	388		582	14
15	Heat Exchanger Replacement/Piping	2017	6,108	382	12	382		382	15
16	Relocation of Circuits per IDPH	2017	2,450	153	12	153		153	16
17									17
18									18
19									19
20	Related Party Allocation -- Bridgemark								20
21	New Office Build Out	2011	11,923		20	631	631	4,074	21
22	Conference Rm Chair Rail & Paint	2012	135		5	18	18	135	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)		$ 5,571,523	$ 923		$ 1,572	$ 649	$ 5,326	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Helia Healthcare of Jerseyville d/b/a Jerseyville Nurs# 0053447 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 33,443	$ 5,742	$ 6,925	$ 1,183	3-15	$ 16,323	71
72	Current Year Purchases	2,872	91	91		3-15	91	72
73	Fully Depreciated Assets	8,251					8,251	73
74								74
75	TOTALS	$ 44,566	$ 5,833	$ 7,016	$ 1,183		$ 24,665	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	Related Party Allocation - Bridgemark			$ 1,167	$	$	$	4	$ 1,167	76
77										77
78										78
79										79
80	TOTALS			$ 1,167	$	$	$		$ 1,167	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)	$ 5,688,920	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 6,756	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 8,588	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,832	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 31,158	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 Helia Healthcare of Jerseyville d/b/a Jerseyville Nursing & 1# 0053447 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 681,639			3
4	Additions							4
5	Storage Rental				2,002			5
6	Related Party Allocation - Bridgemark				8,674			6
7	TOTAL		111		$ 692,315 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
   This amount was calculated by dividing the total amount to be amortized N/A
   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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 32,960 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 Helia Healthcare of Jerseyville d/b/a Jerseyville Nursing & Rehabilitation Center # 0053447 Report Period Beginning: 01/01/17 Ending: 12/31/17

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' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Jerseyville d/b/a Jerseyville Nursing & Rehabilitatio # 0053447 Report Period Beginning: 01/01/17 Ending: 12/31/17

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				409		409	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				159,613		159,613	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Wound, Oxy, Enterals	39,2					23,902		23,902	12
13	Other (specify): X-Rays, Labs, Therapy	39,8				475,963			475,963	13
14	TOTAL			$		$ 475,963	$ 183,924		$ 659,887	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 Helia Healthcare of Jerseyville d/b/a Jerseyville Nursing & I # 0053447 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/17 **(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	$ 13,306	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 279,377)	1,004,669		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	27		7
8	Accounts Receivable (owners or related parties)	1,128,131		8
9	Other(specify): Deposits	127,671		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,273,804	$	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	13,210		15
16	Equipment, at Historical Cost	27,507		16
17	Accumulated Depreciation (book methods)	(12,213)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	65,200		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 93,704	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,367,508	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,023,674	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	179,759		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,972		31
32	Accrued Real Estate Taxes(Sch.IX-B)	86,181		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	26,349		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,326,935	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	56,048		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)**	$ 56,048	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,382,983	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 984,525	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,367,508	$	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name & ID Number Helia Healthcare of Jerseyville d/b/a Jerseyville Nursing & Rehabilita # 0053447 Report Period Beginning: 01/01/17 Ending: 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 919,752	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 919,752	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	64,773	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)**	$ 64,773	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)**	$ 984,525	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Jerseyville d/b/a Jerseyville Nur # 0053447 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 6,561,319	1
2	Discounts and Allowances for all Levels	(120,200)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,441,119	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	147,255	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 147,255	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	24	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)**	$ 24	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,588,398	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	994,717	31
32	Health Care	2,141,924	32
33	General Administration	1,420,348	33
	B. Capital Expense		
34	Ownership	821,735	34
	C. Ancillary Expense		
35	Special Cost Centers	922,917	35
36	Provider Participation Fee	221,984	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,523,625	40
41	**Income before Income Taxes (line 30 minus line 40)****	64,773	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 64,773	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,238,571	44
45	Private Pay - Net Inpatient Revenue	1,462,835	45
46	Medicare - Net Inpatient Revenue	2,392,359	46
47	Other-(specify) Insurance	216,960	47
48	Other-(specify) Hospice	130,394	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,441,119	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 Helia Healthcare of Jerseyville d/b/a Jerseyville Nursing & F # 0053447 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	1,740	2,060	$ 67,766	$ 32.90	1
2	Assistant Director of Nursing	2,157	2,234	65,604	29.37	2
3	Registered Nurses	11,353	11,887	320,042	26.92	3
4	Licensed Practical Nurses	15,009	16,284	385,184	23.65	4
5	CNAs & Orderlies	72,646	78,142	942,156	12.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,207	5,483	58,873	10.74	10
11	Social Service Workers	1,848	2,048	25,223	12.32	11
12	Dietician					12
13	Food Service Supervisor	2,097	2,211	26,740	12.09	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,448	20,417	186,320	9.13	15
16	Dishwashers					16
17	Maintenance Workers	3,304	3,756	59,992	15.97	17
18	Housekeepers	11,354	12,460	123,693	9.93	18
19	Laundry	5,766	6,216	53,866	8.67	19
20	Administrator	1,957	2,184	105,404	48.26	20
21	Assistant Administrator					21
22	Other Administrative	1,938	2,131	31,975	15.00	22
23	Office Manager	3,719	4,317	67,277	15.58	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,219	3,441	46,739	13.58	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	161,762	175,271	$ 2,566,854 *	$ 14.65	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		$ 6,742	1,3	35
36	Medical Director		18,012	9,3	36
37	Medical Records Consultant		1,254	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		7,387	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		3,263	11,3	44
45	Social Service Consultant		1,702	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 38,360		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	935	$ 57,003	10,3	50
51	Licensed Practical Nurses	11	516	10,3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	946	$ 57,519		53

Facility Name & ID Number Helia Healthcare of Jerseyville d/b/a Jerseyville Nursi # 0053447 Report Period Beginning: 01/01/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Suzanne Bellm-Boston	Administrator	0	$ 105,404
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 105,404

B. Administrative - Other

Description	Amount
Bridgemark Healthcare, L.L.C. - Management Fees	$ 335,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 335,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company, L.L.C.	Accounting Services	$ 1,092
Personal Planners	Unemployment Consulting	1,405
Stout Risius Ross, Inc.	Legal Fees	7,041
Ashman & Stein	Legal Fees	652
Paycom Payroll	Payroll Processing	15,057
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 25,247

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 75,435
Unemployment Compensation Insurance	47,197
FICA Taxes	192,814
Employee Health Insurance	31,420
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Match	5,407
Employee Benefits	6,784
Other Employee Insurance	898
Related Party Allocation - Bridgemark	24,585
Related Party Allocation - NW Rehab	78,217
TOTAL (agree to Schedule V, line 22, col.8)	$ 462,757

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	$
Advertising: Employee Recruitment	5,368
Health Care Worker Background Check	3,590
(Indicate # of checks performed)	
Patient Background Checks	
Dues & Subscriptions	11,203
Late Fees	112,827
Miscellaneous Licenses & Fees	
Advertising	18,198
Related Party Allocations	1,002
Less: Public Relations Expense	( )
Non-allowable advertising	(18,198)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 133,990

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	350
Seminar Expense	1,894
Related Party Allocation - Bridgemark	7,941
Related Party Allocation - NW Rehab	4,444
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,629

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Helia Healthcare of Jerseyville d/b/a Jerseyville Nursing & Rehabilitation # 0053447 Report Period Beginning: 01/01/17 Ending: 12/31/17

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $5,035**

(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. $ **17,130** 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. $ **221,984**
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? **Yes** Indicate the amount. $ **24**

(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
12/31/2017

	Description	
16A	Specialty Beds	5,029
16B	Copier Lease	8,750
16C	Dietary Equipment	756
16D	Respiratory Equipment	17,610
16E	Related Party Allocation - Bridgemark Healthcare	815
		32,960