FOR BHF USE

LL1

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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.

I. IDPH License ID Number: 0053454

Facility Name: Montgomery Nursing & Rehab Center

Address: South Route 127, P.O. Box 309 (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: 03/01/2015

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2018 to 12/31/2018 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, LLC, 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 Nursing & Rehab Center # 0053454 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	40,150	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	110	TOTALS	110	40,150	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	23,658	8,109	4,420	36,187	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,658	8,109	4,420	36,187	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.13%

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 110 and days of care provided 3,430

Medicare Intermediary Novitas Solutions

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Montgomery Nursing & Rehab Center # 0053454 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	269,629	19,255	10,038	298,922		298,922		298,922			1
2	Food Purchase		232,969		232,969		232,969	(258)	232,711			2
3	Housekeeping	109,324	39,328	960	149,612		149,612		149,612			3
4	Laundry	66,706	13,066		79,772		79,772		79,772			4
5	Heat and Other Utilities			134,198	134,198		134,198	(27,283)	106,915			5
6	Maintenance	91,266	28,458	62,596	182,320		182,320		182,320			6
7	Other (specify):*											7
8	**TOTAL General Services**	536,925	333,076	207,792	1,077,793		1,077,793	(27,541)	1,050,252			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	1,920,898	155,326	41,283	2,117,507		2,117,507	25,719	2,143,226			10
10a	Therapy		135		135		135		135			10a
11	Activities	62,594	12,560	7,757	82,911		82,911		82,911			11
12	Social Services	52,679		907	53,586		53,586		53,586			12
13	CNA Training					14,142	14,142		14,142			13
14	Program Transportation			12,885	12,885		12,885		12,885			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,036,171	168,021	72,432	2,276,624	14,142	2,290,766	25,719	2,316,485			16
	C. General Administration											
17	Administrative	130,288		300,100	430,388		430,388	(174,167)	256,221			17
18	Directors Fees											18
19	Professional Services			20,691	20,691		20,691	22,030	42,721			19
20	Dues, Fees, Subscriptions & Promotions			80,928	80,928		80,928	(62,720)	18,208			20
21	Clerical & General Office Expenses	70,580	27,513	100,966	199,059		199,059	198,726	397,785			21
22	Employee Benefits & Payroll Taxes			352,775	352,775		352,775	106,334	459,109			22
23	Inservice Training & Education											23
24	Travel and Seminar			16,870	16,870	(14,142)	2,728	12,369	15,097			24
25	Other Admin. Staff Transportation			28,853	28,853		28,853	18,298	47,151			25
26	Insurance-Prop.Liab.Malpractice			136,584	136,584		136,584	1,456	138,040			26
27	Other (specify):*											27
28	**TOTAL General Administration**	200,868	27,513	1,037,767	1,266,148	(14,142)	1,252,006	122,326	1,374,332			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,773,964	528,610	1,317,991	4,620,565		4,620,565	120,504	4,741,069			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 Nursing & Rehab Center #0053454 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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			14,569	14,569		14,569	2,041	16,610			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,477	10,477		10,477	7,447	17,924			32
33	Real Estate Taxes			46,243	46,243		46,243	72	46,315			33
34	Rent-Facility & Grounds			702,184	702,184		702,184	10,470	712,654			34
35	Rent-Equipment & Vehicles			45,819	45,819		45,819	957	46,776			35
36	Other (specify):*											36
37	**TOTAL Ownership**			819,292	819,292		819,292	20,987	840,279			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		116,992	796,639	913,631		913,631	(225,068)	688,563			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			254,033	254,033		254,033		254,033			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		116,992	1,050,672	1,167,664		1,167,664	(225,068)	942,596			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,773,964	645,602	3,187,955	6,607,521		6,607,521	(83,577)	6,523,944			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 Nursing & Rehab Center # 0053454 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	(28,033)	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	(258)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(275)	20		17
18	Fines and Penalties				18
19	Entertainment	(8,160)	21		19
20	Contributions	(407)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(79)	21		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(49,324)	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	(14,819)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (101,355)		$	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)	17,778	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 17,778		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (83,577)		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 Nursing & Rehab Center
ID# 0053454
Report Period Beginning: 01/01/2018
Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	To Eliminated Gifts & Flowers	$ (10,224)	20	1
2	To Eliminate Lobbying & PAC Dues	(2,605)	20	2
3	To Eliminate 2019 IDPH License paid in 2018	(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**	(14,819)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Montgomery Nursing & Rehab Center # 0053454 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	(258)	0	0	0	0	0	0	0	0	0	0	(258)	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	(28,033)	750	0	0	0	0	0	0	0	0	0	(27,283)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(28,291)	750	0	0	0	0	0	0	0	0	0	(27,541)	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	25,509	210	0	0	0	0	0	0	0	0	25,719	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	25,509	210	0	0	0	0	0	0	0	0	25,719	16
	C. General Administration													
17	Administrative	0	(271,590)	97,423	0	0	0	0	0	0	0	0	(174,167)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	22,030	0	0	0	0	0	0	0	0	0	22,030	19
20	Fees, Subscriptions & Promotions	(64,418)	1,687	11	0	0	0	0	0	0	0	0	(62,720)	20
21	Clerical & General Office Expenses	(8,646)	199,322	8,050	0	0	0	0	0	0	0	0	198,726	21
22	Employee Benefits & Payroll Taxes	0	24,278	82,056	0	0	0	0	0	0	0	0	106,334	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	7,110	5,259	0	0	0	0	0	0	0	0	12,369	24
25	Other Admin. Staff Transportation	0	8,238	10,060	0	0	0	0	0	0	0	0	18,298	25
26	Insurance-Prop.Liab.Malpractice	0	1,456	0	0	0	0	0	0	0	0	0	1,456	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(73,064)	(7,469)	202,859	0	0	0	0	0	0	0	0	122,326	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(101,355)	18,790	203,069	0	0	0	0	0	0	0	0	120,504	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Montgomery Nursing & Rehab Center # 0053454 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	2,041	0	0	0	0	0	0	0	0	0	2,041	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	7,447	0	0	0	0	0	0	0	0	7,447	32
33	Real Estate Taxes	0	72	0	0	0	0	0	0	0	0	0	72	33
34	Rent-Facility & Grounds	0	10,470	0	0	0	0	0	0	0	0	0	10,470	34
35	Rent-Equipment & Vehicles	0	0	957	0	0	0	0	0	0	0	0	957	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	12,583	8,404	0	0	0	0	0	0	0	0	20,987	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	(225,068)	0	0	0	0	0	0	0	0	(225,068)	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	(225,068)	0	0	0	0	0	0	0	0	(225,068)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(101,355)	31,373	(13,595)	0	0	0	0	0	0	0	0	(83,577)	45

Facility Name & ID Number Montgomery Nursing & Rehab Center # 0053454 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Stephen P. Miller	100	Helia Healthcare of Belleville	Belleville, IL	Bridgemark Healthcar	St. Louis, MO	Management Co.
		Helia Healthcare of Benton	Benton, IL	Helia Healthcare Servi	Benton, IL	Laundry, Maint.
		Helia Healthcare of Florissant	Florissant, MO	Bridgemark Employer	St. Louis, MO	Human Resources
		Helia Healthcare of Champaign	Champaign, IL	NW Rehab LLC	St. Louis, MO	Therapy
		Helia Healthcare of Energy	Energy, IL			
		Helia Healthcare of Olney	Olney, 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%	$ 750	$ 750	1
2	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	25,509	25,509	2
3	V	17	Management Fees	300,100	Bridgemark Healthcare, LLC	100.00%	28,510	(271,590)	3
4	V	19	Professional Services		Bridgemark Healthcare, LLC	100.00%	22,030	22,030	4
5	V	20	Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	1,687	1,687	5
6	V	21	Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	199,322	199,322	6
7	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	24,278	24,278	7
8	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	7,110	7,110	8
9	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	8,238	8,238	9
10	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	1,456	1,456	10
11	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	2,041	2,041	11
12	V	33	Real Estate Tax		Bridgemark Healthcare, LLC	100.00%	72	72	12
13	V	34	Rent		Bridgemark Healthcare, LLC	100.00%	10,470	10,470	13
14	Total			$ 300,100			$ 331,473	$ * 31,373	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Montgomery Nursing & Rehab Center # 0053454 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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%	$ 957	$ 957	15
16	V								16
17	V								17
18	V	10	Nursing & Medical Records		NW Rehab, LLC	100.00%	210	210	18
19	V	39	Therapy	722,194	NW Rehab, LLC	100.00%	497,126	(225,068)	19
20	V	17	Admin Salaries		NW Rehab, LLC	100.00%	97,423	97,423	20
21	V	20	Dues & Subscriptions		NW Rehab, LLC	100.00%	11	11	21
22	V	21	Clerical & Office Supplies		NW Rehab, LLC	100.00%	8,050	8,050	22
23	V	22	Employee Benefits		NW Rehab, LLC	100.00%	82,056	82,056	23
24	V	24	Travel & Seminar		NW Rehab, LLC	100.00%	5,259	5,259	24
25	V	25	Other Admin Transp		NW Rehab, LLC	100.00%	10,060	10,060	25
26	V	32	Interest		NW Rehab, LLC	100.00%	7,447	7,447	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 722,194			$ 708,599	$ * (13,595)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Montgomery Nursing & Rehab Center # 0053454 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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			Helia Healthcare of Effingham	Effingham, IL				6
7			Helia Healthcare of Salem	Salem, IL				7
8			Palladian Senior Care of Poplar Bluff, LLC	Poplar Bluff, MO				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 Nursing & Rehab Center # 0053454 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	271,490	4.75	9.50	Distribution	$ 28,510	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	$ 28,510		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 Nursing & Rehab Center # 0053454 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

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) 457-9176

	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	380,780	15	$ 7,897	$	36,187	$ 750	1
2	10	Nursing & Medical Records	Resident Days	380,780	15	268,418	268,418	36,187	25,509	2
3	17	Owner's Compensation	Resident Days	380,780	15	300,000		36,187	28,510	3
4	19	Professional Fees	Resident Days	380,780	15	231,817		36,187	22,030	4
5	20	Dues, Subscriptions	Resident Days	380,780	15	17,755		36,187	1,687	5
6	21	Salaries - Other	Resident Days	380,780	15	1,800,224	1,800,224	36,187	171,082	6
7	21	Clerical & Office Supplies	Resident Days	380,780	15	297,152		36,187	28,240	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	380,780	15	255,471		36,187	24,278	8
9	24	Seminars	Resident Days	380,780	15	74,815		36,187	7,110	9
10	25	Admin Staff Travel	Resident Days	380,780	15	86,690		36,187	8,238	10
11	26	Insurance	Resident Days	380,780	15	15,316		36,187	1,456	11
12	30	Depreciation	Resident Days	380,780	15	21,481		36,187	2,041	12
13	33	Real Estate Taxes	Resident Days	380,780	15	753		36,187	72	13
14	34	Building Rent	Resident Days	380,780	15	102,060		36,187	9,699	14
15	34	Rental - Storage	Resident Days	380,780	15	8,118		36,187	771	15
16	35	Equipment Rental	Resident Days	380,780	15	10,066		36,187	957	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,498,033	$ 2,068,642		$ 332,430	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Montgomery Nursing & Rehab Center # 0053454 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

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	10	Nursing & Medical Records	Revenue	2,717,752	19	$ 792	$	722,194	$ 210	1
2	39	Therapy	Revenue	2,717,752	19	1,870,778	1,870,778	722,194	497,126	2
3	17	Admin Salaries	Revenue	2,717,752	19	366,622	366,622	722,194	97,423	3
4	20	Dues & Subscriptions	Revenue	2,717,752	19	41		722,194	11	4
5	21	Clerical & Office Supplies	Revenue	2,717,752	19	30,294		722,194	8,050	5
6	22	Employee Benefits	Revenue	2,717,752	19	308,794		722,194	82,056	6
7	24	Travel & Seminar	Revenue	2,717,752	19	19,790		722,194	5,259	7
8	25	Other Admin Transportation	Revenue	2,717,752	19	37,856		722,194	10,060	8
9	32	Interest	Revenue	2,717,752	19	28,025		722,194	7,447	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,662,992	$ 2,237,400		$ 707,642	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Montgomery Nursing & Rehab Center # 0053454 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	10,477	6
7	Related Part Allocation										7,447	7
8												8
9	TOTAL Facility Related						$	$			$ 17,924	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 17,924	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 Montgomery Nursing & Rehab Center # 0053454 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	61,607	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.)	$	61,923	2
3. Under or (over) accrual (line 2 minus line 1).	$	316	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	$	45,927	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.	$	46,243	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2013	52,025	8
2014	55,230	9
2015	54,589	10
2016	46,326	11
2017	46,243	12

46, 243 Line 7, Real Estate Tax portion of Lease Payments
72 Bridgemark Healthcare Allocation
46,315 Total Schedule V, Line 33

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Montgomery Nursing & Rehab Center COUNTY Montgomery

FACILITY IDPH LICENSE NUMBER 0053454

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE FAX #:

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(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	$ 46,243.00	$ 46,243.00
2.		Taylor Springs 8-4-716 3/4 S13	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 46,243.00	$ 46,243.00

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 Nursing & Rehab Center # 0053454 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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? [ ] (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 Nursing & Rehab Center # 0053454 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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 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	Beauty Shop Remodeling			1998	566						28
29	Shower Room Remodeling			1998	6,040						29
30	Shelving			1998	208						30
31	Wall Mounted Laundry Tab			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 Nursing & Rehab Center # 0053454 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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 Lights	2004	1,145						42
43	Tile	2004	878						43
44	Commercial Water Heater	2004	7,664						44
45	Floor Tile	2004	1,186						45
46	66 Gallon Hot Water Heater	2004	931						46
47	Patio & Sidewalks	2004	14,316						47
48	Concrete Dumpster Pad/ Fencing	2004	1,520						48
49	Range Hood	2005	832						49
50	Closet Door - Resident Rooms	2005	3,689						50
51	Outside Lighting Features	2005	2,025						51
52	Air Conditioning Unit	2005	7,610						52
53	Electrical Work	2005	5,528						53
54	Tile & Cove Base	2005	2,064						54
55	Heating/ Cooling Unit	2005	558						55
56	Wallpaper	2005	811						56
57	Therapy Room Cabinets	2005	1,200						57
58	New Roof - 200 & 500 Wings	2005	74,745						58
59	Wall Guard	2006	570						59
60	6 Oak Doors	2006	3,469						60
61	Smoke Detectors	2006	683						61
62	Exhausted Fans for Kitchen	2006	1,034						62
63	New Roof- 300 Wing	2007	30,200						63
64	Shower & Wall Remodel	2007	5,510						64
65	Water Heaters	2006	1,695						65
66	Air Conditioning Unit	2006	3,414						66
67	Storage Shed	2006	1,583						67
68	Fire Doors	2006	4,939						68
69	Patio & 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 Nursing & Rehab Center # 0053454 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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 Rooms	2007	20,896						3
4	Water Heaters	2007	10,972						4
5	Doors - Metal	2007	4,450						5
6	Air Conditioning Units	2007	3,512						6
7	Flooring	2007	10,399						7
8	Landscaping - Sign Area	2007	2,575						8
9	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 Storage	2008	8,602						14
15	8 Oak Doors	2008	4,659						15
16	In Wall Fountain - Labor & Materials	2008	5,321						16
17	Handrails & Hardware	2008	8,950						17
18	Cabinets, Countertops, & Sinks	2008	28,200						18
19	5 Shaped Cornices	2008	3,034						19
20	Cabinet Installation	2008	3,320						20
21	3 A/C Units	2009	1,839						21
22	Sinks/Faucets - Resident Rooms	2009	2,985						22
23	Generator	2009	50,432						23
24	Roof Replacement - 100 & 400 Halls	2009	36,200						24
25	10 Upholstered Cornices	2009	5,255						25
26	Wi-Fi Access Installation	2009	1,892						26
27	Ceiling Tiles - Therapy Room	2009	676						27
28	Plexiglass for Maint. Shed	2009	758						28
29	Closet Doors	2009	548						29
30	New Entry Door	2010	3,000						30
31	4 AC/Heat Units	2010	2,618						31
32	Neww 400 Amp Breaker	2010	1,787						32
33	Flooring	2010	5,340						33
34	TOTAL (lines 1 thru 33)		$ 1,866,023	$		$	$	$	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Montgomery Nursing & Rehab Center # 0053454 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	Kitchen Flooring	2011	4,520						3
4	Breaker Panel & Installation	2011	10,994						4
5	Sprinkler System	2011	117,500						5
6	6 AC/ Heat Units	2011	4,502						6
7	Motion Senor/Detectors	2011	1,094						7
8	Water Heaters	2011	1,145						8
9	Sidewalks	2011	3,850						9
10	Vinyl Fence and Gate	2011	5,325						10
11	Asphalt/Seal/Stripe/Patch & Repair Parking Lot	2011	28,870						11
12	Drainage Downspounts Installation	2011	2,880						12
13	Windows - Remove and Replace	2012	9,480						13
14	Flooring - Shower Room	2012	4,602						14
15	Flooring - Lunch Room	2012	1,783						15
16	2 Electric Heater/ AC Units	2012	1,605						16
17	Security Locks	2012	7,870						17
18	Light Fixtures - Weather Proof	2012	4,471						18
19	100 Gal. Hot Water Heater	2012	8,042						19
20	10 AC/ Heat Units	2013	7,491						20
21	New Breaker for Lighting	2013	2,466						21
22	Nurse Call System Upgrade	2013	7,082						22
23	Electrical Work - 2 New Circuits	2013	1,615						23
24	5 New Vinyl Doors	2013	765						24
25	Hot Water Heater (10 Gal.) & Missing Valve	2013	2,239						25
26	5 Ton 13 Seer Rooftop A/C Unit	2013	6,071						26
27	400 & 500 Half Light Fixtures	2013	3,195						27
28	Plumbing for Stool & Lavatory	2013	2,457						28
29	Lighting Receptacles, fixtures, and ballasts	2014	5,418						29
30	New Cabinets, handles, and locks	2014	10,075						30
31	Relief Valve on Sprinkler System	2014	1,565						31
32	A/C Units	2014	10,016						32
33	Electrical Work	2014	24,349						33
34	TOTAL (lines 1 thru 33)		$ 2,184,160	$		$	$	$	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Montgomery Nursing & Rehab Center # 0053454 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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		4,533	10
11	Bathroom Remodel	2017	20,778	2,078	10	2,078		2,770	11
12	Shower Room Remodel	2017	4,353	435	10	435		617	12
13	Rehab Room Heat Pump - Ductless	2018	3,610	331	10	331		331	13
14									14
15									15
16									16
17									17
18									18
19									19
20	Related Part Allocation - Bridgemark:								20
21	New Office Build Out	2011	12,907		20	683	683	5,094	21
22	Conference Rm Chair Rail & Paint	2012	146		5			146	22
23	AC Unit in Server Room	2018	1,001		20	25	25	25	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)		$ 2,253,199	$ 4,204		$ 4,912	$ 708	$ 13,516	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 Nursing & Rehab Center # 0053454 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 44,732	$ 6,680	$ 7,836	$ 1,156	3-15	$ 21,414	71
72	Current Year Purchases	23,477	1,935	2,112	177	3-15	2,112	72
73	Fully Depreciated Assets	11,007					11,007	73
74								74
75	TOTALS	$ 79,216	$ 8,615	$ 9,948	$ 1,333		$ 34,533	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Van		2017	$ 7,000	$ 1,750	$ 1,750	$	4	$ 2,771	76
77	Related Party Allocation - Bridgemark			1,263				4	1,263	77
78										78
79										79
80	TOTALS			$ 8,263	$ 1,750	$ 1,750	$		$ 4,034	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)	$ 2,368,351	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 14,569	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 16,610	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,041	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 52,083	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 Nursing & Rehab Center # 0053454 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: OMG Hillsboro Property, 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		$ 699,907			3
4	Additions							4
5	Storage Rental				2,277			5
6	Related Party Allocation - Bridgemark				10,470			6
7	TOTAL		110		$ 712,654 **			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 N/A .

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

10. Effective dates of current rental agreement:
Beginning 05/07/2018
Ending 4/30/2038

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

	Fiscal Year Ending	Annual Rent
12.	12/31/2019	$
13.	12/31/2020	$
14.	12/31/2021	$

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: $ 46,775 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	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 Nursing & Rehab Center # 0053454 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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		544		544
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments		13,598		13,598
8	CNA Competency Tests				
9	TOTALS	$	$ 14,142	$	$ 14,142
10	SUM OF line 9, col. 1 and 2 (e)	$ 14,142			

C. CONTRACTUAL INCOME

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

$ None

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	26
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	26

(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 Nursing & Rehab Center # 0053454 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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				135		135	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				88,610		88,610	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Wound, Oxy, Enterals	39,2					28,382		28,382	12
13	Other (specify): X-Ray, Labs, Therapy	39,8				571,571			571,571	13
14	TOTAL			$		$ 571,571	$ 117,127		$ 688,698	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 Nursing & Rehab Center # 0053454 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018 (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	$ 3,402	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 200,000)	1,635,611		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,229		7
8	Accounts Receivable (owners or related parties)	1,018,191		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,658,433	$	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	35,540		15
16	Equipment, at Historical Cost	66,539		16
17	Accumulated Depreciation (book methods)	(29,539)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	45,927		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 118,467	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,776,900	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,594,629	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	236,485		30
31	Accrued Taxes Payable (excluding real estate taxes)	15,653		31
32	Accrued Real Estate Taxes(Sch.IX-B)	45,927		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	16,699		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,909,393	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	30,353		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)**	$ 30,353	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,939,746	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 837,154	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,776,900	$	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name & ID Number Montgomery Nursing & Rehab Center # 0053454 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 325,640	1
2	Restatements (describe):		2
3	**Prior Year Adjustments After Cost Report Filed**	33,731	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 359,371	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	477,783	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)**	$ 477,783	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)**	$ 837,154	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Montgomery Nursing & Rehab Center # 0053454 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 6,578,391	1
2	Discounts and Allowances for all Levels	(80,248)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,498,143	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	438,543	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 438,543	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous - Prior Year Late Fee Reversed	148,618	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 148,618	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,085,304	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,077,793	31
32	Health Care	2,276,624	32
33	General Administration	1,266,148	33
	B. Capital Expense		
34	Ownership	819,292	34
	C. Ancillary Expense		
35	Special Cost Centers	913,631	35
36	Provider Participation Fee	254,033	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,607,521	40
41	**Income before Income Taxes (line 30 minus line 40)****	477,783	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 477,783	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,164,282	44
45	Private Pay - Net Inpatient Revenue	1,281,088	45
46	Medicare - Net Inpatient Revenue	1,763,684	46
47	Other-(specify) Insurance	241,327	47
48	Other-(specify) Hospice	47,762	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,498,143	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 Nursing & Rehab Center # 0053454 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	2,082	2,296	$ 87,337	$ 38.04	1
2	Assistant Director of Nursing	1,697	2,004	59,937	29.91	2
3	Registered Nurses	6,710	7,172	219,802	30.65	3
4	Licensed Practical Nurses	19,334	21,533	461,376	21.43	4
5	CNAs & Orderlies	79,083	85,070	1,039,490	12.22	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	369	369	4,094	11.09	8
9	Activity Director					9
10	Activity Assistants	5,419	5,852	62,594	10.70	10
11	Social Service Workers	1,854	2,112	52,679	24.94	11
12	Dietician					12
13	Food Service Supervisor	1,854	2,131	47,925	22.49	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,391	20,114	221,704	11.02	15
16	Dishwashers					16
17	Maintenance Workers	4,106	4,607	91,266	19.81	17
18	Housekeepers	10,128	11,079	109,324	9.87	18
19	Laundry	6,255	6,840	66,706	9.75	19
20	Administrator	1,802	2,073	106,621	51.43	20
21	Assistant Administrator	689	844	23,667	28.04	21
22	Other Administrative	2,001	2,182	26,509	12.15	22
23	Office Manager	2,320	2,605	44,071	16.92	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,754	3,022	48,862	16.17	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	166,848	181,905	$ 2,773,964 *	$ 15.25	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 10,038	1,3	35
36	Medical Director		9,600	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		10,223	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		7,757	11,3	44
45	Social Service Consultant		907	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 38,525		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

Facility Name & ID Number Montgomery Nursing & Rehab Center # 0053454 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Carla Vonder Haar	Administrator	0	$ 106,621
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 106,621

B. Administrative - Other

Description	Amount
Bridgemark Healthcare, LLC - Management Fees	$ 300,100
TOTAL (agree to Schedule V, line 17, col. 3)	$ 300,100
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company, LLC	Accounting Services	$ 2,175
Personal Planners, LLC	Unemployment Consulting	1,743
Paycom Payroll	Payroll Processing	16,694
Collection Fee	Eliminated	79
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 20,691

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 53,908
Unemployment Compensation Insurance	41,589
FICA Taxes	208,519
Employee Health Insurance	40,723
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Match	6,165
Employee Benefits	755
Other Employee Insurance	1,116
Related Party Allocation - Bridgemark	24,278
Related Party Allocation - NW Rehab	82,056
TOTAL (agree to Schedule V, line 22, col.8)	$ 459,109

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	3,868
Health Care Worker Background Check	1,451
(Indicate # of checks performed)	
Patient Background Checks	
Dues & Subscriptions	8,951
Late Fees	
Miscellaneous Licenses & Fees	250
Advertising	49,324
Related Party Relations Expense	1,698
Less: Public Relations Expense	( )
Non-allowable advertising	(49,324)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,208

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,728
Related Party Allocation - Bridgemark	7,110
Related Party Allocation - NW Rehab	5,259
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 15,097

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

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 $4,534**

(3) Did the nursing home make political contributions or payments to a politica
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?

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **31,954** 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 fo
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 Departmen
during this cost report period. $ **254,033**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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 fo
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 othe
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
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
12/31/2018

	Description	
16A	Specialty Bed Rental	30,316
16B	Respiratory Equipment	7,473
16C	Copier Lease	6,980
16D	Related Party Allocation - Bridgemark Healthcare	957
16E	Dietary Equipment	1,050
		46,776