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.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I. IDPH License ID Number: 0053447

Facility Name: Jerseyville Nsg Rehab Center

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

County: Jersey

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

HFS ID Number:

Date of Initial License for Current Owners: 03/01/15

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 01/01/2020 to 12/31/2020 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 Jerseyville Nsg Rehab Center # 0053447 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	40,626	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	40,626	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,874	6,643	5,109	24,626	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,874	6,643	5,109	24,626	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.62%

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 3,796

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: 12/31/20 Fiscal Year: 12/31/20

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Jerseyville Nsg Rehab Center # 0053447 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	161,707	25,314	6,975	193,996		193,996		193,996			1
2	Food Purchase		161,541		161,541		161,541	(216)	161,325			2
3	Housekeeping	113,106	25,362	800	139,268		139,268		139,268			3
4	Laundry	47,258	11,544		58,802		58,802		58,802			4
5	Heat and Other Utilities			150,180	150,180		150,180	(8,284)	141,896			5
6	Maintenance	82,187	28,234	58,276	168,697		168,697		168,697			6
7	Other (specify):*											7
8	**TOTAL General Services**	404,258	251,995	216,231	872,484		872,484	(8,500)	863,984			8
	B. Health Care and Programs											
9	Medical Director			18,012	18,012		18,012		18,012			9
10	Nursing and Medical Records	1,569,339	127,504	242,899	1,939,742		1,939,742	36,975	1,976,717			10
10a	Therapy		215		215		215		215			10a
11	Activities	51,726	5,214	2,208	59,148		59,148	(746)	58,402			11
12	Social Services	36,759		1,799	38,558		38,558		38,558			12
13	CNA Training											13
14	Program Transportation			116	116		116		116			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,657,824	132,933	265,034	2,055,791		2,055,791	36,229	2,092,020			16
	C. General Administration											
17	Administrative	106,062		280,600	386,662		386,662	(255,901)	130,761			17
18	Directors Fees											18
19	Professional Services			87,379	87,379		87,379	8,020	95,399			19
20	Dues, Fees, Subscriptions & Promotions			46,026	46,026		46,026	(30,723)	15,303			20
21	Clerical & General Office Expenses	140,391	15,242	155,967	311,600		311,600	124,138	435,738			21
22	Employee Benefits & Payroll Taxes			316,055	316,055		316,055	14,342	330,397			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,748	1,748		1,748	2,162	3,910			24
25	Other Admin. Staff Transportation			4,652	4,652		4,652	3,087	7,739			25
26	Insurance-Prop.Liab.Malpractice			519,365	519,365		519,365	20,794	540,159			26
27	Other (specify):*											27
28	**TOTAL General Administration**	246,453	15,242	1,411,792	1,673,487		1,673,487	(114,081)	1,559,406			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,308,535	400,170	1,893,057	4,601,762		4,601,762	(86,352)	4,515,410			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 Jerseyville Nsg Rehab Center #0053447 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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			26,302	26,302		26,302	3,510	29,812			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,143	9,143		9,143	(1,137)	8,006			32
33	Real Estate Taxes			67,200	67,200		67,200	38	67,238			33
34	Rent-Facility & Grounds			741,116	741,116		741,116	6,493	747,609			34
35	Rent-Equipment & Vehicles			30,073	30,073		30,073	965	31,038			35
36	Other (specify):*											36
37	TOTAL Ownership			873,834	873,834		873,834	9,869	883,703			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		119,492	405,508	525,000		525,000	82,664	607,664			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			193,721	193,721		193,721		193,721			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		119,492	599,229	718,721		718,721	82,664	801,385			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,308,535	519,662	3,366,120	6,194,317		6,194,317	6,181	6,200,498			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 Jerseyville Nsg Rehab Center # 0053447 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	(746)	11		4
5	Telephone, TV & Radio in Resident Rooms	(8,774)	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	(1,137)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(216)	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	(2,860)	20		18
19	Entertainment	(3,202)	21		19
20	Contributions	(50)	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	(22,618)	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	(6,422)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (46,250)		$	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)	52,431	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 52,431		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 6,181		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

Jerseyville Nsg Rehab Center
ID# 0053447
Report Period Beginning: 01/01/2020
Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	To Eliminate Gifts and Flowers	$ (3,598)	20	1
2	To Offset Medical Records Income	(95)	10	2
3	To Eliminate Lobbying & PAC Dues	(2,729)	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
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19				19
20				20
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22				22
23				23
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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**	(6,422)		49

Facility Name & ID Number Jerseyville Nsg Rehab Center # 0053447 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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. Ann, MO	Management Co
		Helia Healthcare of Benton	Benton, IL	Helia Healthcare serv.	Benton, IL	Laundry, Maint
		Frankfort Healthcare & Rehab Center	West Frankfort, IL	Bridgemark Employer	St. Louis, MO	Human Resources
		Helia Southbelt Healthcare	Belleville, IL	NW Rehab, LLC	St. Louis, MO	Therapy
		Helia Healthcare of Energy	Energy, IL	Palladian Managemen	O'Fallon, IL	Management Co
		Helia Healthcare of Olney	Olney, IL	Palladian Taylorville A	Taylorville, IL	Assisted Living
		Helia Healthcare of Newton	Newton, IL	Palladian Mt. Vernon A	Mt. Vernon, IL	Assisted Living

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%	$ 490	$ 490	1
2	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	27,402	27,402	2
3	V	17	Management Fees	280,600	Bridgemark Healthcare, LLC	100.00%	24,699	(255,901)	3
4	V	19	Professional Services		Bridgemark Healthcare, LLC	100.00%	8,020	8,020	4
5	V	20	Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	1,307	1,307	5
6	V	21	Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	127,390	127,390	6
7	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	14,342	14,342	7
8	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	2,162	2,162	8
9	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	3,087	3,087	9
10	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	20,794	20,794	10
11	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	3,510	3,510	11
12	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	38	38	12
13	V	34	Rent		Bridgemark Healthcare, LLC	100.00%	6,493	6,493	13
14	Total			$ 280,600			$ 239,734	$ * (40,866)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Jerseyville Nsg Rehab Center # 0053447 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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%	$ 965	$ 965	15
16	V								16
17	V								17
18	V								18
19	V	10	CNA Assistance during COVID	44,080	NW Rehab, LLC	100.00%	53,748	9,668	19
20	V	39	Therapy	376,844	NW Rehab, LLC	100.00%	459,508	82,664	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								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			$ 420,924			$ 514,221	$ * 93,297	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Jerseyville Nsg Rehab Center # 0053447 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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			Hillside Rehab & Care Center	Yorkville, IL				1
2			Helia Healthcare of Hillsboro	Hillsboro, IL				2
3			Helia Healthcare of Florissant	Florrisant, MO				3
4			Helia Healthcare of Poplar Bluff	Poplar Bluff, MO				4
5			Helia Healthcare of Effingham	Effingham, IL				5
6			Helia Healthcare of Salem	Salem, IL				6
7			Palladian Senior Care of Poplar Bluff	Poplar Bluff, MO				7
8			Helia Richland Healthcare, LLC	Olney, IL				8
9			Palladian Aviston SNF, LLC	Aviston, IL				9
10			Palladian Mt. Vernon SNF, LLC	Mt. Vernon, IL				10
11			Palladian Taylorville SNF, LLC	Taylorville, IL				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 Jerseyville Nsg Rehab Center # 0053447 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	381,729	3.04	6.08	Distribution	$ 24,699	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	$ 24,699		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 Jerseyville Nsg Rehab Center # 0053447 Report Period Beginning: 01/01/2020 Ending: 2/31/2020

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: 500 NW Plaza Dr., Suite 712
City / State / Zip Code: Saint Ann, MO 63074
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	405,225	17	$ 8,060	$	24,626	$ 490	1
2	10	Nurisng & Medical Supplies	Resident Days	405,225	17	450,909	450,909	24,626	27,402	2
3	17	Owner's Compensation	Resident Days	405,225	17	406,428		24,626	24,699	3
4	19	Professional Fees	Resident Days	405,225	17	131,963		24,626	8,020	4
5	20	Dues, Subscription	Resident Days	405,225	17	21,510		24,626	1,307	5
6	21	Salaries - Other	Resident Days	405,225	17	1,662,655	1,662,655	24,626	101,042	6
7	21	Clerical & Office Supplies	Resident Days	405,225	17	433,562		24,626	26,348	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	405,225	17	235,995		24,626	14,342	8
9	24	Seminars	Resident Days	405,225	17	35,584		24,626	2,162	9
10	25	Admin Staff Travel	Resident Days	405,225	17	50,795		24,626	3,087	10
11	26	Insurance	Resident Days	405,225	17	342,172		24,626	20,794	11
12	30	Depreciation	Resident Days	405,225	17	57,762		24,626	3,510	12
13	33	Real Estate Taxes	Resident Days	405,225	17	629		24,626	38	13
14	34	Building Rent	Resident Days	405,225	17	97,672		24,626	5,936	14
15	34	Rental - Storage Unit	Resident Days	405,225	17	9,163		24,626	557	15
16	35	Equipment Rental	Resident Days	405,225	17	15,876		24,626	965	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,960,735	$ 2,113,564		$ 240,699	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Jerseyville Nsg Rehab Center # 0053447 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	Medline		X	Vendor Note		11/15/19				8.0000	727	5
	Working Capital											
6	MidCap Funding I, LLC		X	Line of Credit		10/22/09				Variable	8,123	6
7	HFS		X			7/1/19					245	7
8	OmniCare		X	Vendor Note						7.5000	48	8
9	TOTAL Facility Related						$	$			$ 9,143	9
	B. Non-Facility Related*											
10	Interest Income Offset										(1,137)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,137)	14
15	TOTALS (line 9+line14)						$	$			$ 8,006	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 Jerseyville Nsg Rehab Center # 0053447 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 67,200	2
3. Under or (over) accrual (line 2 minus line 1).		$ 67,200	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 67,200	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	85,927	8
	2016	86,180	9
	2017	67,440	10
	2018	66,359	11
	2019	67,921	12

67,200 Line 7, Portion of Lease Payment Allocated to Real Estate Taxes

38 Related Party Allocation - Bridgemark

67,238 Total Schedule V, Line 33

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Jerseyville Nsg Rehab Center 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 2019 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 2019.

	(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	$ 63,271.20	$ 63,271.20
2.		Outlot 62	$	$
3.	04-208-017-00	S&W PT SE 1/4 NE 1/4 Less E PT	$ 4,649.64	$ 4,649.64
4.		Less .10 ACS for HWY	$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 67,920.84	$ 67,920.84

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

Facility Name & ID Number Jerseyville Nsg Rehab Center # 0053447 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Jerseyville Nsg Rehab Center # 0053447 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	Eelctrical			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	Const. of 400 Wing - Design, Architecture, and Engineering			2001	65,216						36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Jerseyville Nsg Rehab Center # 0053447 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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 System Cabeling	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 2P AMP Discount	2001	8,932						57
58	2P 50 AMP Discount	2001	955						58
59	Mini Blinds	2001	14,744						59
60	Asphalt 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 Jerseyville Nsg Rehab Center # 0053447 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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 Tranfer 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 Conditioners	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 System 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 Jerseyville Nsg Rehab Center # 0053447 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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 Wing	2206	15,869						3
4	Smoke Damper Motor	2006	1,793						4
5	Vinyl Fencing	2006	12,359						5
6	Concrete Patio & Sidewalk	2006	10,744						6
7	Landscaping, Rock, Mulch	2006	4,325						7
8	Wallpaper	2007	12,135						8
9	Air Conditioners	2007	16,341						9
10	Flooring	2007	31,280						10
11	Alarm System	2007	4,732						11
12	Handrails	2007	11,039						12
13	Roof	2007	5,700						13
14	Satelite System	2007	16,581						14
15	Electrical For HV AV Unit	2007	3,964						15
16	Courtyard Landscaping	2007	3,800						16
17	Courtyard 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	Lanscaping	2008	5,700						29
30	Flooring	2008	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 Jerseyville Nsg Rehab Center # 0053447 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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 - Existing Facility	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 Electrical	2011	475						21
22	Conference Room Labor & Material	2011	4,231						22
23	Conference Room Plumbing	2011	2,200						23
24	Conference Room Cabinet Allowance	2011	500						24
25	Conference Room Electrical	2011	825						25
26	2 Electric 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 Jerseyville Nsg Rehab Center # 0053447 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 5,506,154	$		$	$	$	1
2	3 A/C/Heat Units	2013	2,358						2
3	Oxygen Storage Facility	2013	1,124						3
4	Concrete Pad & Sidewalk	2013	2,250						4
5	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	Current Owner Additions:								13
14	Stage 1 Compressor Replacement	2016	4,652	388	12	388		1,744	14
15	Heat Exchanger Replacement/Piping	2017	6,108	509	12	509		1,909	15
16	Relocation of Circuits per IDPH	2017	2,450	204	12	204		766	16
17	Replace Heat Pump	2018	20,840	1,389	15	1,389		3,126	17
18	Roof Repairs	2018	9,280	928	10	928		2,010	18
19	East & West Wing RTU & 3 Exhausters	2019	23,935	2,394	10	2,394		4,787	19
20	Facility Roof Replacement	2019	209,707	10,485	20	10,485		20,097	20
21	New Compressor in RTU - 400 Hall	2019	7,067	707	10	707		1,119	21
22	6 Ton TRU in Kitchen area	2019	14,998	1,500	10	1,500		2,250	22
23	1200BTU PTAC 20 amp - HD Supply	2020	1,690	169	5	169		169	23
24	Replace Heat Exchanger on East Boiler - Baer	2020	5,386		10				24
25	Smoke Alarms	2020	3,850	160	10	160		160	25
26									26
27									27
28									28
29	Related Party Allocation - Bridgemark								29
30	New Office Build Out	2011	8,254		20	437	437	4,132	30
31	Conference Rm Chair Rail & Paint	2012	93		5			93	31
32	AC Unit in Server Room	2018	640		20	32	32	80	32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,865,205	$ 18,833		$ 19,302	$ 469	$ 42,442	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Jerseyville Nsg Rehab Center # 0053447 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	$ 50,270	$ 5,765	$ 8,400	$ 2,635	3-15	$ 20,363	71
72	Current Year Purchases	21,350	1,704	2,110	406	3-15	2,110	72
73	Fully Depreciated Assets	10,941					10,941	73
74								74
75	TOTALS	$ 82,561	$ 7,469	$ 10,510	$ 3,041		$ 33,414	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 6,019,430	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 26,302	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 29,812	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,510	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 75,856	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 Jerseyville Nsg Rehab Center # 0053447 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: OMG Jerseyville 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:		111		$ 739,686			3
4	Additions							4
5	Storage Rental				1,430			5
6	Related Party Allocation - Bridgemark				6,493			6
7	TOTAL		111		$ 747,609 **			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 5/7/18
Ending 4/30/38

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

	Fiscal Year Ending	Annual Rent
12.	/2021	$
13.	/2022	$
14.	/2023	$

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

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

16. Rental Amount for movable equipment: $ 31,038 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

Helia Healthcare of Jerseyville
Attachment to Schedule XII B
Equipment Rentals
12/31/2020

	Description	
16A	Nursing Equipment Rentals	11,108
16B	Respiratory Equipment	275
16C	Copier Lease	17,442
16D	Dietary Equipment	1,248
16E	Related Party Allocation - Bridgemark Healthcare	965
		31,038

Facility Name & ID Number Jerseyville Nsg Rehab Center # 0053447 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

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				215		215	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				88,472		88,472	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Wound, Oxy, Enterals	39, 2					31,019		31,019	12
13	Other (specify): X-Rays, Labs, Therapy	39, 3				488,172			488,172	13
14	TOTAL			$		$ 488,172	$ 119,706		$ 607,878	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

STATE OF ILLINOIS

Facility Name & ID Number Jerseyville Nsg Rehab Center # 0053447 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2020 (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	$ 14,584	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (10,000))	649,179		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	559,767		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,223,530	$	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	309,963		15
16	Equipment, at Historical Cost	67,823		16
17	Accumulated Depreciation (book methods)	(62,745)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 315,041	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,538,571	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 254,927	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	83,547		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,175		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Assessment Tax	10,780		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 351,429	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 351,429	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,187,142	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,538,571	$	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name & ID Number Jerseyville Nsg Rehab Center # 0053447 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,399,799	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,399,799	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(212,657)	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)**	$ (212,657)	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)**	$ 1,187,142	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Jerseyville Nsg Rehab Center # 0053447 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,502,612	1
2	Discounts and Allowances for all Levels	(382,879)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,119,733	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	105,512	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 105,512	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***	1,137	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,137	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	CARES Funds	750,933	28
28a	Miscellaneous	4,345	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 755,278	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,981,660	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	872,484	31
32	Health Care	2,055,791	32
33	General Administration	1,673,487	33
	B. Capital Expense		
34	Ownership	873,834	34
	C. Ancillary Expense		
35	Special Cost Centers	525,000	35
36	Provider Participation Fee	193,721	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,194,317	40
41	**Income before Income Taxes (line 30 minus line 40)****	(212,657)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (212,657)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,158,475	44
45	Private Pay - Net Inpatient Revenue	1,082,633	45
46	Medicare - Net Inpatient Revenue	1,549,730	46
47	Other-(specify) Insurance	176,760	47
48	Other-(specify) Hospice	152,135	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,119,733	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 Jerseyville Nsg Rehab Center # 0053447 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	2,075	2,171	$ 91,924	$ 42.34	1
2	Assistant Director of Nursing	2,475	2,616	98,464	37.64	2
3	Registered Nurses	7,046	7,530	255,417	33.92	3
4	Licensed Practical Nurses	13,377	14,327	377,249	26.33	4
5	CNAs & Orderlies	43,677	46,861	714,507	15.25	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,831	4,095	51,726	12.63	10
11	Social Service Workers	1,912	2,130	36,759	17.26	11
12	Dietician					12
13	Food Service Supervisor	1,841	2,046	29,579	14.46	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,326	12,250	132,127	10.79	15
16	Dishwashers					16
17	Maintenance Workers	4,070	4,391	82,187	18.72	17
18	Housekeepers	9,272	10,103	113,106	11.20	18
19	Laundry	3,949	4,276	47,258	11.05	19
20	Administrator	1,888	2,167	106,062	48.94	20
21	Assistant Administrator					21
22	Other Administrative	3,051	3,492	63,218	18.10	22
23	Office Manager	4,288	4,892	77,173	15.78	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,679	1,891	31,779	16.81	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	115,757	125,238	$ 2,308,535 *	$ 18.43	34

* 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		$ 6,975	1, 3	35
36	Medical Director		18,012	9, 3	36
37	Medical Records Consultant		742	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		7,777	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		2,208	11, 3	44
45	Social Service Consultant		1,799	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 37,513		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	381	$ 30,252	10, 3	50
51	Licensed Practical Nurses	373	21,837	10, 3	51
52	Certified Nurse Assistants/Aides	3,250	112,108	10, 3	52
53	TOTAL (lines 50 - 52)	4,004	$ 164,197		53

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Jerseyville Nsg Rehab Center # 0053447 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Keri Shatley	Administrator	0	$ 94,950
Suzanne Bellm-Boston	Administrator	0	11,112
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 106,062

B. Administrative - Other

Description	Amount
Bridgemark Healthcare, LLC - Management Fees	$ 280,600
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 280,600

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	Unemployment Consulting	$ 1,916
Lashly & Baer, P.C.	Legal Fees	50,955
Hamlin & Burton Liability Managem	Legal Fees	4,458
C.J. Schlosser & Company, LLC	Accounting Services	4,000
Nationwide Trust	401k Admin	978
Hepler Broom LLC	Legal Fees	4,678
Pantegra	401k Admin	3,100
Paycom Payroll	Payroll Processing	17,294
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 87,379

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 26,344
Unemployment Compensation Insurance	13,543
FICA Taxes	175,345
Employee Health Insurance	59,071
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401k Match	4,930
Employee Benefits	36,822
Related Party Allocation - Bridgemark	14,342
TOTAL (agree to Schedule V, line 22, col.8)	$ 330,397

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	2,330
Health Care Worker Background Check	1,820
(Indicate # of checks performed)	
Patient Background Checks	
Dues & Subscriptions	3,648
IHCA Dues	5,796
Miscellaneous Licenses & Fees	402
Advertising	22,618
Related Party Allocation	1,307
Less: Public Relations Expense	( )
Non-allowable advertising	(22,618)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,303

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,748
Related Party Allocation - Bridgemark	2,162
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,910

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Jerseyville Nsg Rehab Center # 0053447 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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 $5,796**

(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. $ **13,026** 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. $ **193,721**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' PREPARATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **None**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.